

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER W. ABELL			2a. DATE OF DEATH MONTH DAY YEAR 9 / 19 / 84		2b. HOUR 6:45 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) College Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b. KIND OF BUSINESS OR INDUSTRY Stock	
13a. STATE MD		13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 151 Versailles Cr., 21204		14. FATHER'S NAME FIRST MIDDLE LAST Arunah S. Abell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Schley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW I 217 20 5009		17. INFORMANT ADDRESS Mrs. Caroline A. Coleman, Balto., MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Verticilar fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 5 days 3 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/6 1960 to 9/19 1984, that (I) saw the deceased alive on 9/17 1984, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. William F. Fritz, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/19/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. F. Fritz		22e. ADDRESS 21204 Versailles Cr. Balto. 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/24/84		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212				25a. DATE REC'D. BY REGISTRAR SEP 25 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		4 2 3 4 7 3				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy P. Adams					2a. DATE OF DEATH MONTH DAY YEAR Sept. 9, 1984			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 28, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2914 Liberty Pkwy. Apt. D 21222				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Dundalk					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21222 2914 Liberty Pkwy. Apt. D		
14. FATHER'S NAME FIRST MIDDLE LAST John A. Decker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Murphy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-28-9268		17. INFORMANT ADDRESS 21236 Dolores Davison 9126 Cowenton Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Michael Schwartz M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL SCHWARTZ					22e. ADDRESS 606 HAMMONDS LAKE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-12-84		23c. NAME OF CEMETERY OR CREMATORY Beaver Creek		23d. LOCATION CITY OR TOWN COUNTY STATE Washington Co., Md.			
24. FUNERAL DIRECTOR Connelly Funeral Home of Dundalk					25a. DATE REC'D. BY REGISTRAR SEP 13 1984				

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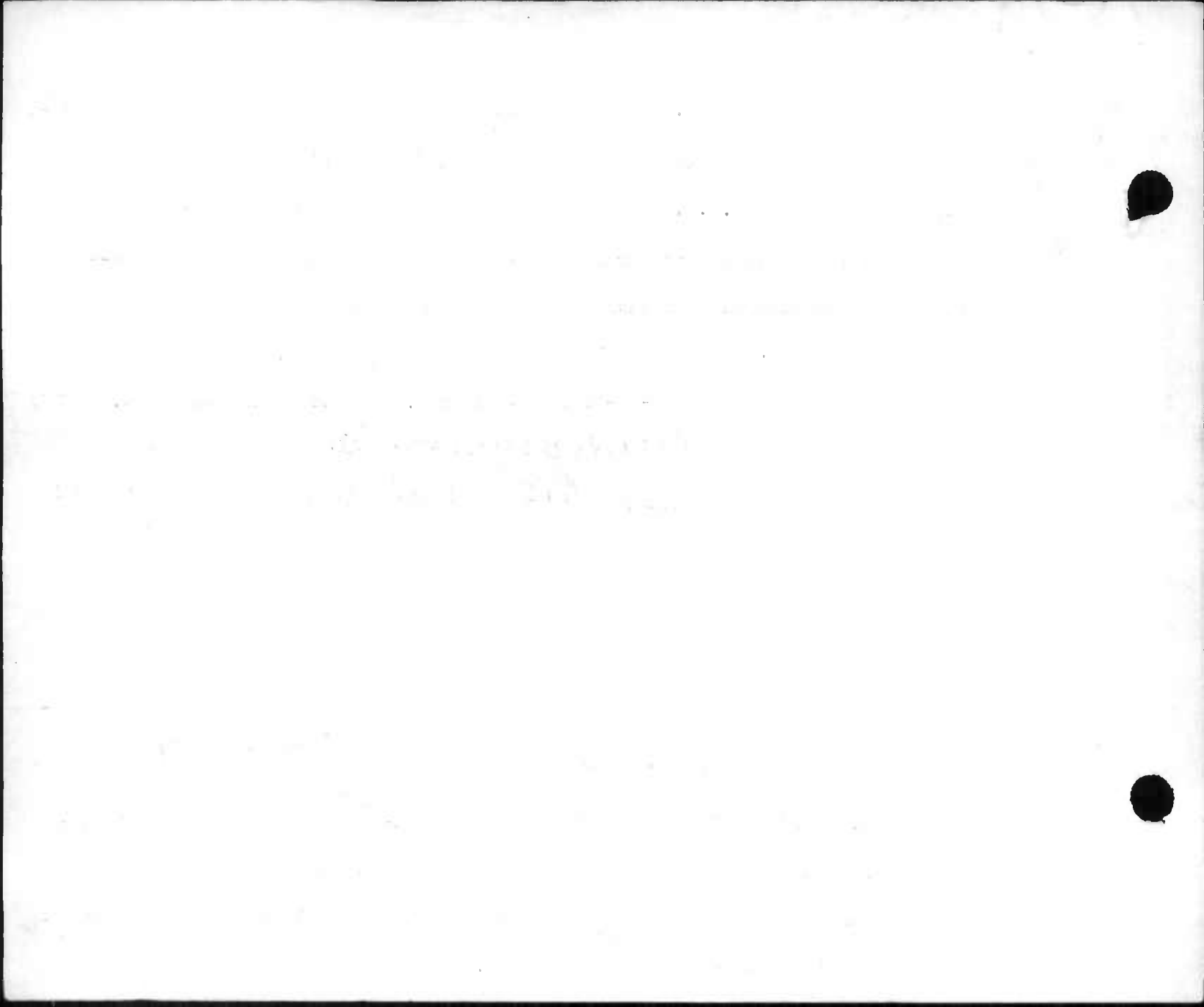
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST EMMA	MIDDLE T.	LAST ALBIKER	2a. DATE OF DEATH MONTH DAY YEAR 9 14 84	2b. HOUR 11:55 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 27 1888		6. AGE (IN YEARS LAST BIRTHDAY) 96	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Inglennook Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Arbutus	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4415 Leeds Avenue 21229		
14. FATHER'S NAME FIRST MIDDLE LAST John C. Kuhber		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma T. Campbell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-01-3913	17. INFORMANT ADDRESS Charles L. Albiker 4415 Leeds Ave. 21229				
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9-14-84</u> 19 <u>84</u> to <u>9-14-84</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>9-14-84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) I did not view the body after death.						
22b. SIGNATURE <u>James J. McPhillips</u> MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/17/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James J. McPhillips		22e. ADDRESS 5550 Baltimore National Pike, 21228				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/18/84	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR SEP 17 1984		

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Josephine      Jacquelin      Alecce			2a. DATE OF DEATH MONTH      DAY      YEAR September 10, 1984		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH      DAY      YEAR Aug. 17, 1904	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS      DAYS      HOURS      MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9819 Pulaski Hwy. 21220		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY White Marsh	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST      MIDDLE      LAST Andrew           Maggio			15. MOTHER'S MAIDEN NAME FIRST      MIDDLE      LAST unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-76-1608	17. INFORMANT ADDRESS ### A. Andrew Alecce 2401 Ravenview Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (CARCINOMA OF STOMACH) EMACIATION DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA STOMACH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION 8/21/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF STOMACH		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR      A.M.      MONTH      DAY      YEAR P.M.      19      84	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK      AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET      CITY OR TOWN      COUNTY      STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/21/84, 1984, to 8/31, 1984, that (I) (we) last saw the deceased alive on 8/31, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (TYPE OR PRINT)				22d. DATE SIGNED 9/10/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/12/84	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN      COUNTY      STATE Towson      Baltimore Co.      Md.
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Rd.			25a. DATE REC'D. BY REGISTRAR SEP 11 1984		

September 1, 1961

Minneapolis

Dear Sir:

Thank you

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Very truly yours,  
[Signature]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23476

1. DECEASED NAME (TYPE OR PRINT) <b>MARY LOUISE ALSTON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9 29 84</b>		2b. HOUR <b>11:50 AM</b>	
3. SEX <b>Female F</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 30, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>	
10. CITY OR TOWN OF DEATH <b>Towson MD</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Lutherville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>806 Roundtop Ct. Apt. 1D 21093</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Waller</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Henriette Phoebe</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-05-3577</b>		17. INFORMANT ADDRESS <b>Patricia L. Gray, same as #13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> , 19 <b>84</b> to <b>9/29</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M.C. Capogrossi</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9.29.84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M.C. CAPOGROSSI</b>		22e. ADDRESS <b>STH</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10-1-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>OCT 2 1984</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>1050 York Rd. Towson, Md. 21204</b>		25. REGISTRAR'S SIGNATURE <b>John A. Anderson</b>	

BP

RECEIVED  
JULY 30, 1903

RECEIVED  
JULY 30, 1903

JULY 30, 1903

JULY 30, 1903

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JULY 30, 1903

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Thomas Patrick Arthur Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 30, 1984</b>		2b. HOUR <b>5:37p</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 5, 1921</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.						
10. CITY OR TOWN OF DEATH <b>Essex</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Musician</b>		
12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Rosedale</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2 Fernsell Ct 21237</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas P Arthur Sr</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Frank</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 216-16-1389</b>		17. INFORMANT ADDRESS <b>Mrs Mildred V Arthur Same As 13e</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sepsis</b> (c) <b>Adenocarcinoma Of The Lung And Esophagus</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Upper Gastiointestinal Bleeding</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 27, 1984</b> to <b>Sept 30, 1984</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Sept. 30, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.						
22b. SIGNATURE <b>J. Rodriguez, MD</b>				22c. DATE SIGNED <b>9-30-1984</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Isabel Rodriguez, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/3/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>						
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>		
				25b. REGISTRAR'S SIGNATURE <b>Gina Davidson-Randall</b>		

X





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

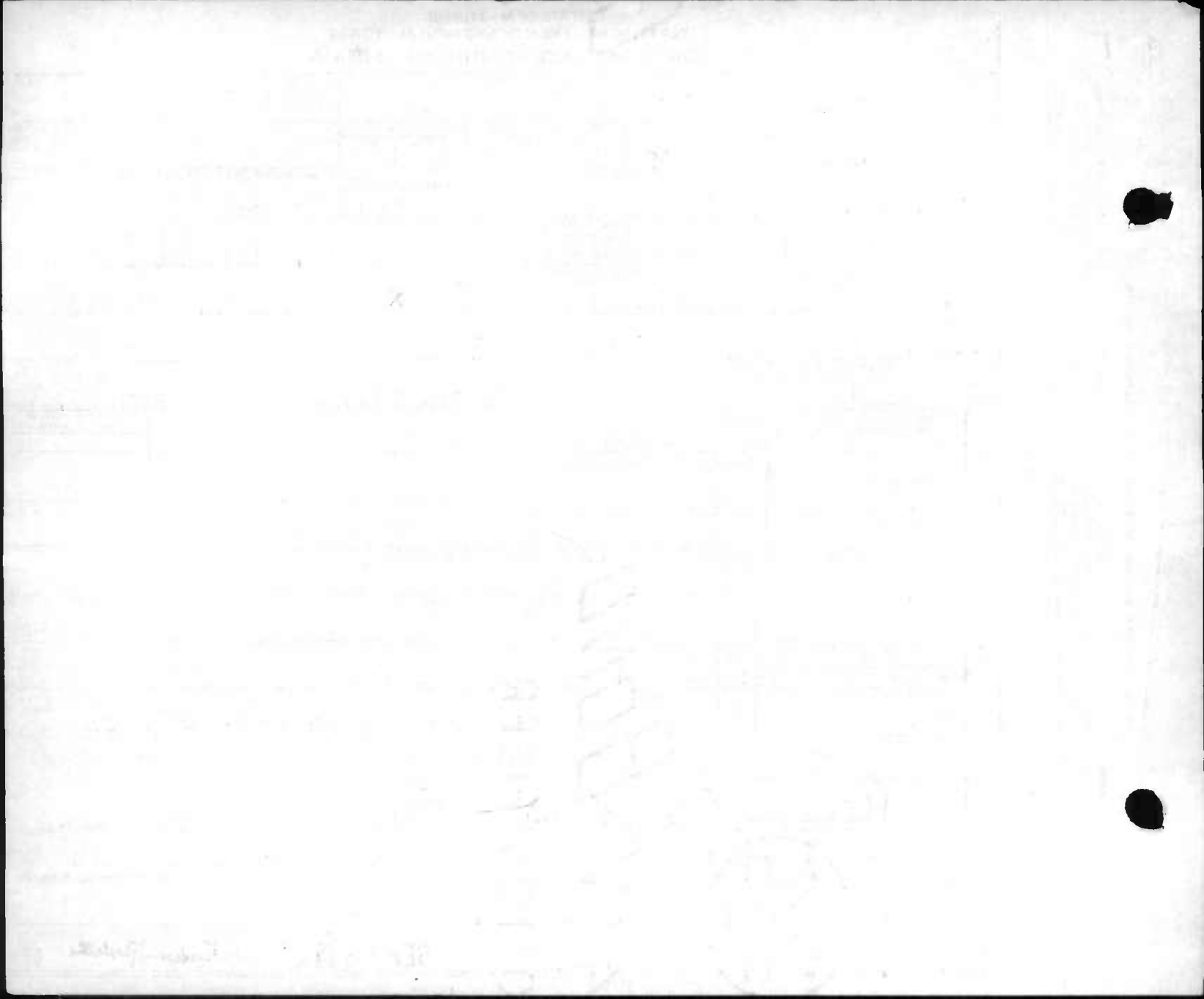
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

23478

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BARBARA MARY FRANKLIN AVERY</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> MATED <input type="checkbox"/> <b>9-14 1984</b>			2b. HOUR <b>11:45 P. M.</b>		
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>8</b> YEAR <b>49</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>35</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	IF UNDER 24 HRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>9-14 1984</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO., MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Baltimore County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Pikesville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5A Tentmill Lane</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BALTO. CITY SCHOOL</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>PIKESVILLE</b>		13c. CITY OR TOWN <b>PIKESVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <b>WILLIAM</b> MIDDLE <b>COLE</b> LAST <b>COLE</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARGARET</b> MIDDLE <b>PALMER</b> LAST <b>PALMER</b>		16. SOCIAL SECURITY NO. <b>219-52-4465</b>				
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		17b. INFORMANT <b>MARGARET FRANKLIN</b>		17c. ADDRESS <b>3202 ESSEX RD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Head</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>11:30pm</b> MONTH <b>9</b> DAY <b>14</b> YEAR <b>1984</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject was shot</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET <b>5A Tentmill Lane</b> CITY OR TOWN <b>Pikesville</b> COUNTY <b>Balto. Co.</b> STATE <b>Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>9-15-84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>9/18/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEM.</b>		23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <b>LEROY O. DYETT &amp; SON FUNERAL HOME, INC.</b>			ADDRESS			25a. DATE RECEIVED BY REGISTRAR <b>SEP 18 1984</b>		
						25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		



2

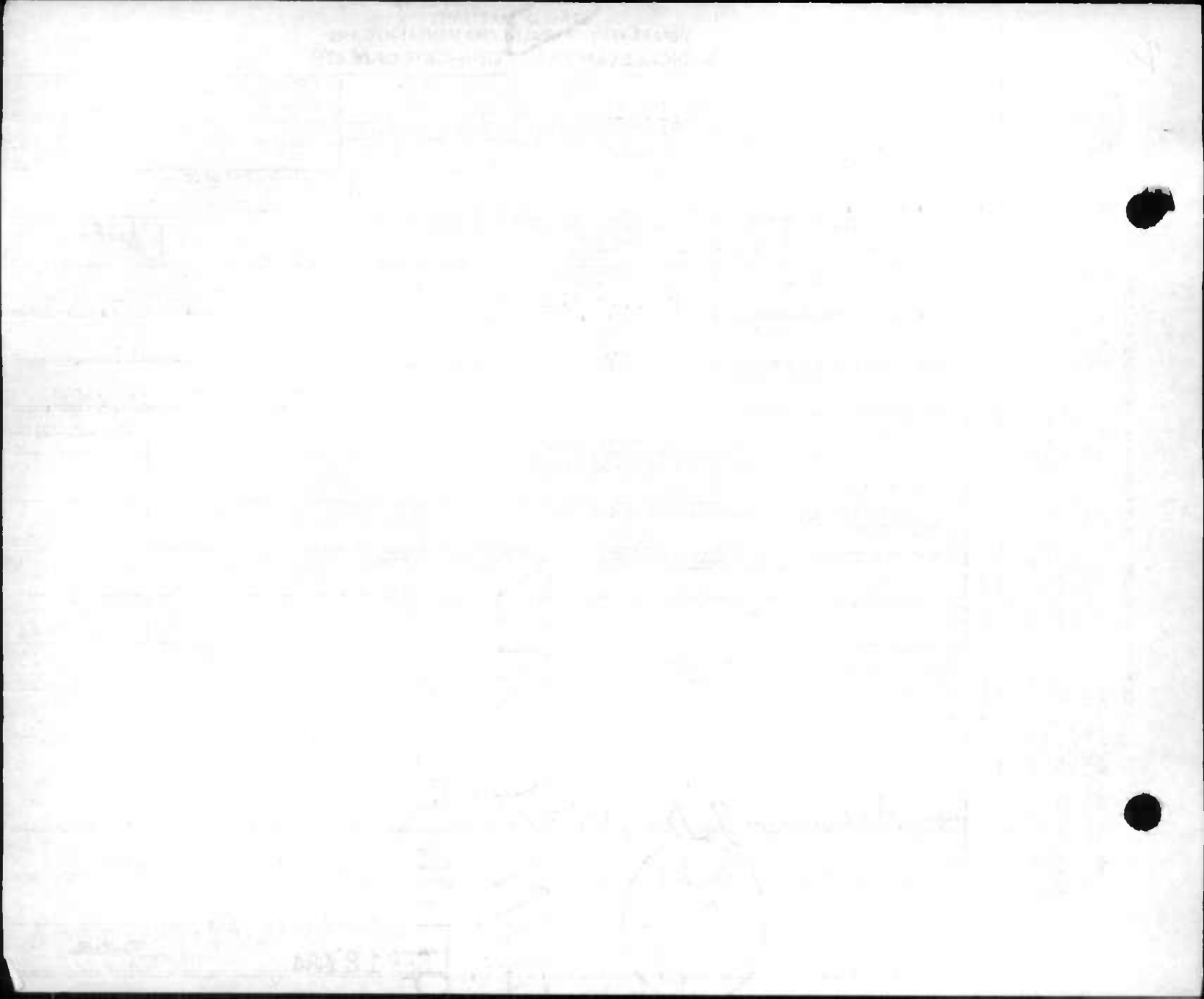
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
Film #599 item 5 1- STATE REGISTRAR 1/25/85 IJJ MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 2 3 4 7 9									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Caula DENEENE Avery						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9-14 19 84		2b. HOUR M 11:45 P. M.	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 12 4 78	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 14	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-14 19 84		2d. HOUR M 11:45 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.			
10. CITY OR TOWN OF DEATH Pikesville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5A Tentmill Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY PIKESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21208 5 TENTMILL LANE APT. A			
14. FATHER'S NAME FIRST MIDDLE LAST LARRY				15. MOTHER'S M maiden name FIRST MIDDLE LAST BARBARA FRANKLIN		16. SOCIAL SECURITY NO. MARGARET FRANKLIN 3202 Essex Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INSURANCE ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun Wound of Head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) <u>subject was shot</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>subject was shot</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOURS MONTH DAY YEAR 11:30pm 9-14 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5A Tentmill Lane, Pikesville, Balto. Co., Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER						DATE SIGNED 9-15-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/18/84		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., Md.			
24. FUNERAL DIRECTOR NAME LEROY O. DYETT		ADDRESS 4600 LIBERTY HGTS. AVE.		25a. DATE REC'D. BY REGISTRAR SEP 18 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

BP

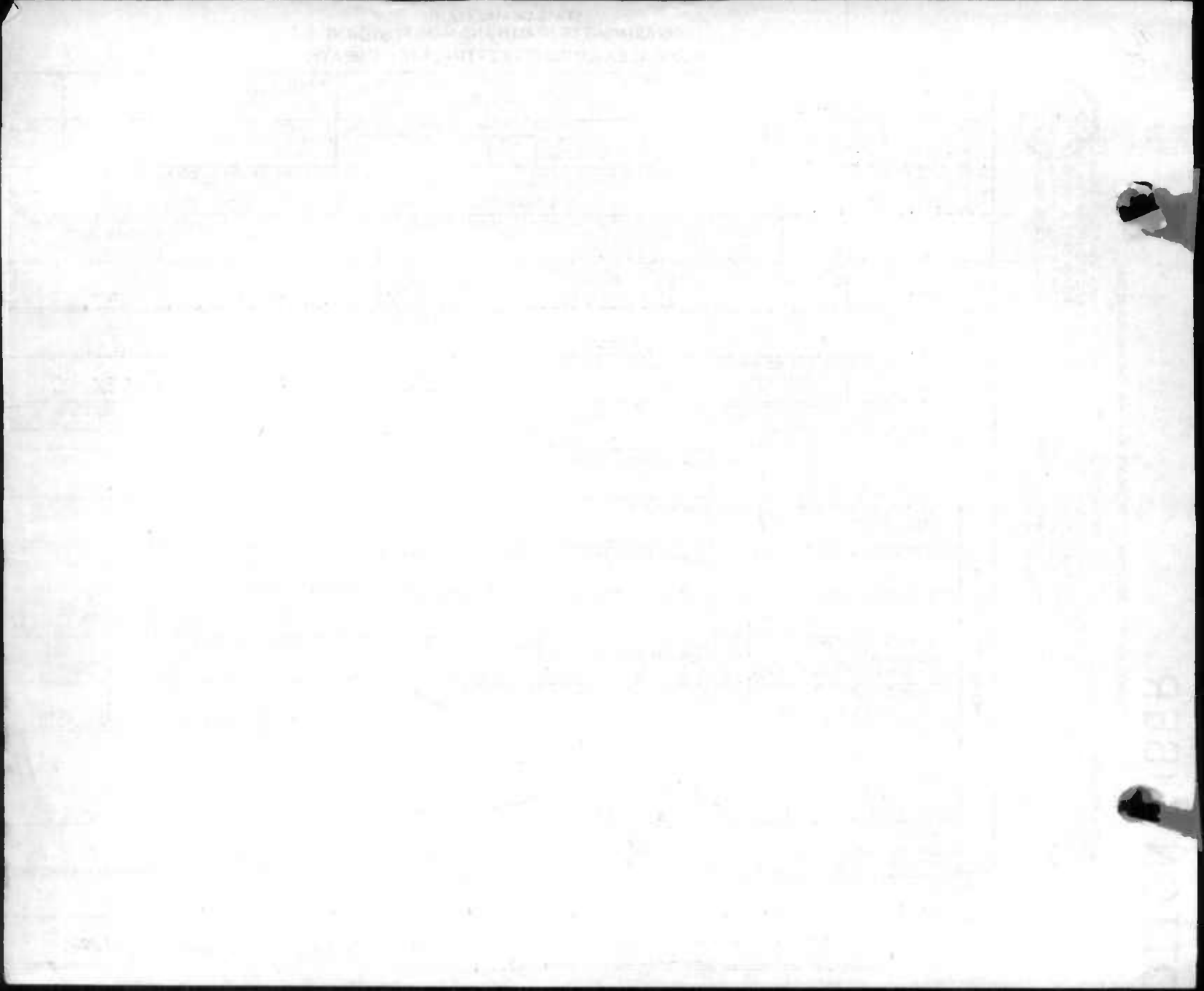
 DHMH - 17  
 (VR A15 ME (5))  
 20M 4/82



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, DIRECTOR OF THE HEALTH DEPARTMENT SHALL BE NOTIFIED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23480	
1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Katasha JANEL Avery			2a. DATE KNOWN OF DEATH EST. MATED 9-14 19 84			2b. HOUR 11:45 P. M.		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 4 8 76		6. AGE (IN YEARS) (LAST BIRTHDAY) 8 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 9-14 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH Pikesville			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5A Tentmill Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.			13b. COUNTY PIKESVILLE			13c. CITY OR TOWN PIKESVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST LARRY AVERY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARBARA FRANKLIN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		
17. INFORMANT ADDRESS MARGARET FRANKLIN 3202 ESSEX RD.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun Wound of Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 11:30pm 9-14 19 84			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject was shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5A Tentmill Lane, Pikesville, Balto. Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .			ACTUAL SIGNATURE Dennis F. Smyth, M.D.			TITLE (SPECIFY) Assistant MEDICAL EXAMINER			DATE SIGNED 9-15-84		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn Street, Balto., Md. 21201			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/18/84		
23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.			24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HGTS. AVE.			25a. DATE REC'D. BY REGISTRAR SEP 18 1984		
25b. REGISTRAR'S SIGNATURE			26. REGISTRAR'S SIGNATURE			27. REGISTRAR'S SIGNATURE			28. REGISTRAR'S SIGNATURE		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 1/2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

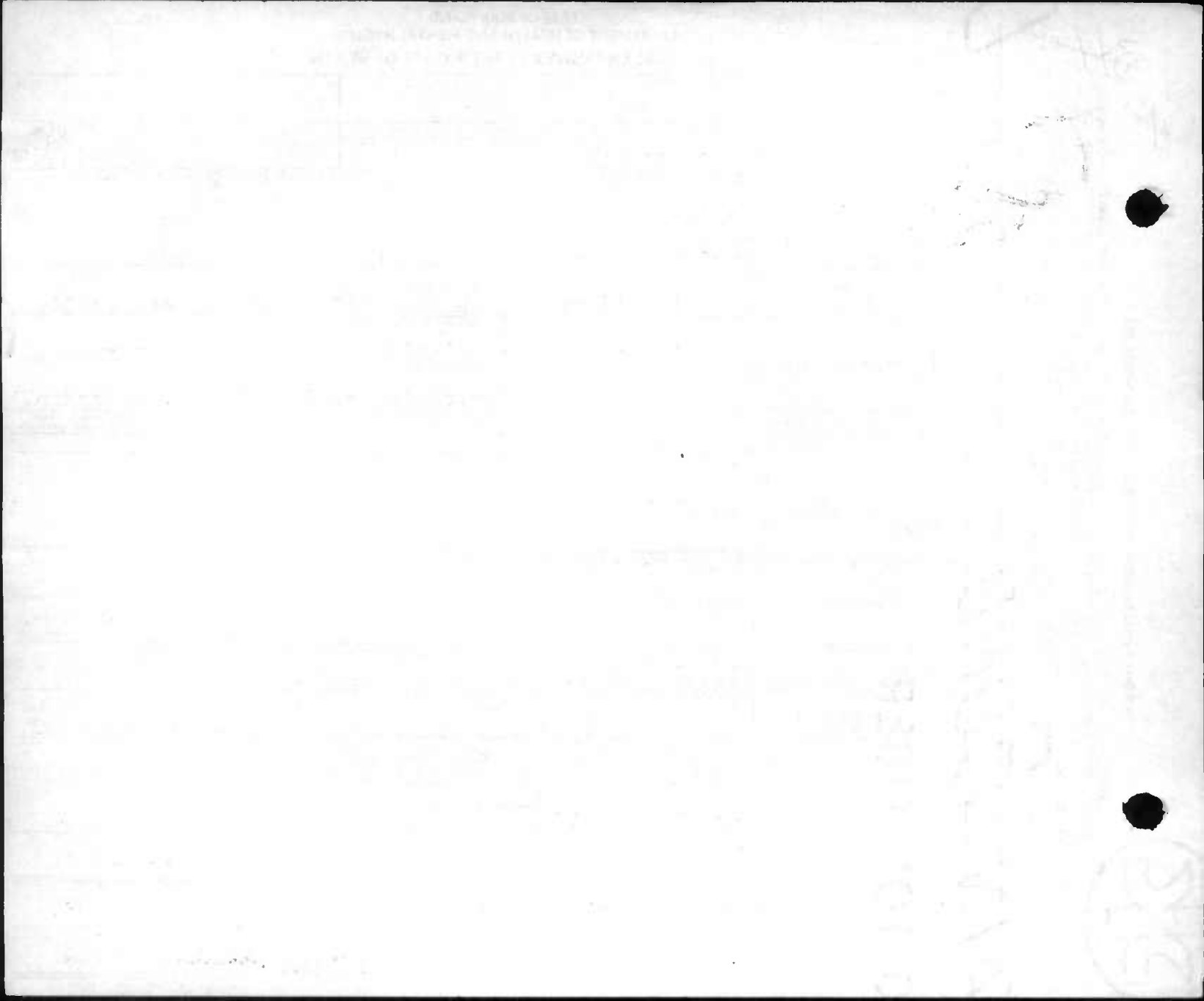
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 213481

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR										2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										2c. DATE OF EST. DEATH MATED <input type="checkbox"/> MONTH DAY YEAR										2d. HOUR	
LARRY AVERY										9-14 1984										M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR							
male		black		6 9 51		33 YRS.						9-14 1984		11:45 P. M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
N. Carolina				U.S.A.								Baltimore County, MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Pikesville				5A Tentmill Lane																	
13a. STATE				13b. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS									
Maryland				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				5408 Harford Road 21214									
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																	
James Forman				Minnie Avery																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
YES								Patricia Gatling 1339 N. Patterson Pk													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of Head																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last																					
(b) DUE TO, OR AS A CONSEQUENCE OF																					
(c) DUE TO, OR AS A CONSEQUENCE OF																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
11:30pm 9-14 1984				subject shot himself																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
Home				5A Tentmill Lane, Pikesville, Balto. Co., MD.																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED													
Dennis F. Smyth M.D.				Assistant				9-15-84													
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
Dennis F. Smyth, M.D.				111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL				9/20/84				Garriosn Forest VA				Owings Mills, Md.									
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Wm C March F/H Inc.				1101 E North Avenue				SEP 17 1984				Julia Davidson-Randall									





**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **2 3 4 8 2**

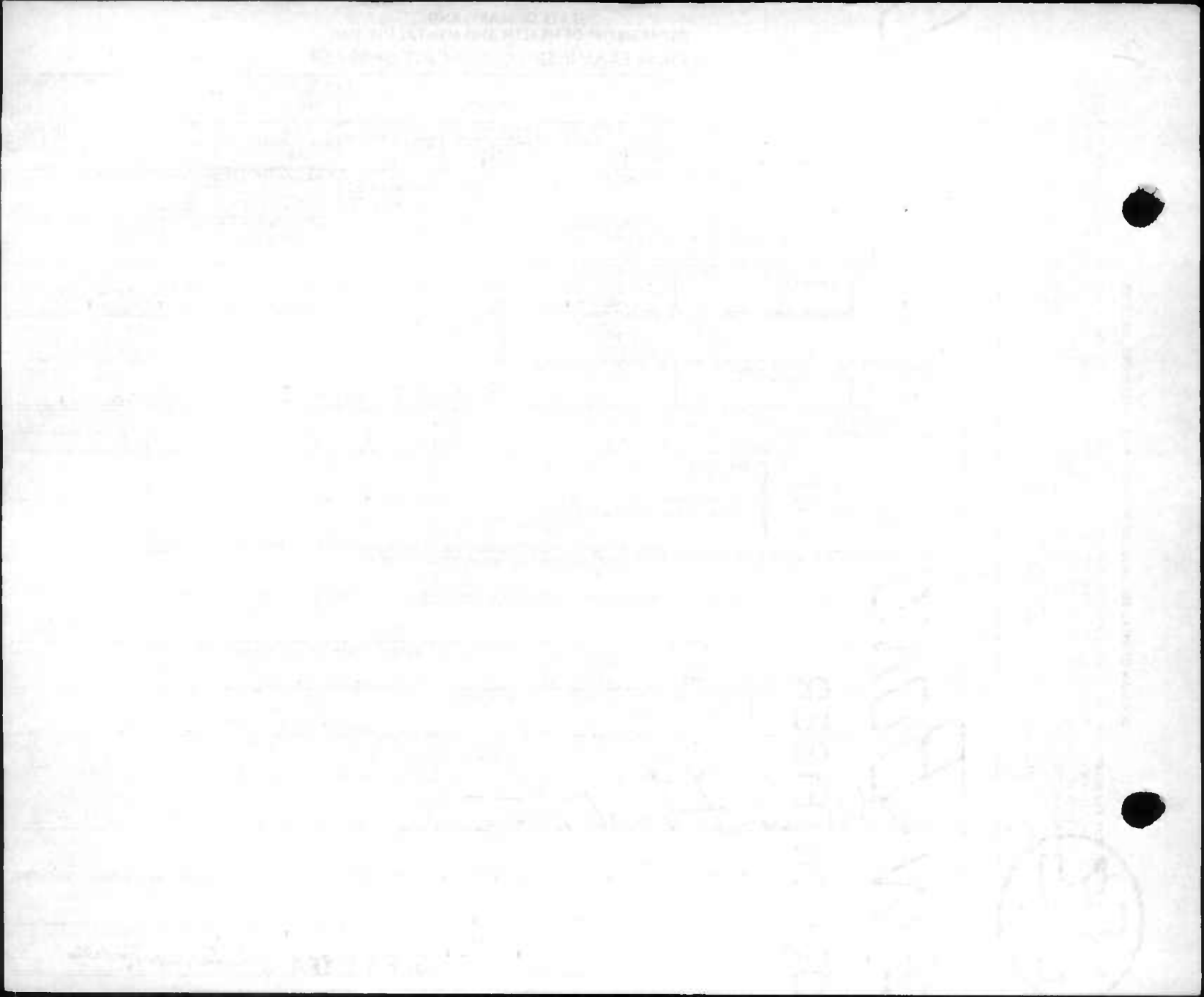
**1- FOR  
STATE  
REGISTRAR**

1. DECEASED NAME (TYPE OR PRINT) <b>Robert J.P. Avery</b>			7a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9-14 1984</b>			7b. HOUR <b>M</b>		
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 10 84</b>	6. AGE (IN YEARS) YEARS MONTHS DAYS <b>7Mo.</b>	IF UNDER 1 YR. HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9-14 1984</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTO., Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Pikesville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5A Tentmill Lane</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. STATE <b>Md.</b>			13b. COUNTY <b>PIKESVILLE</b>			13c. CITY OR TOWN <b>PIKESVILLE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>LARRY AVERY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BARBARA FRANKLIN</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, Md.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>MARGARET FRANKLIN 3202 Essex Rd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
20. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>11:30pm 9-14 1984</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject was shot</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5A Tentmill Lane, Pikesville, Balto. Co., Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth M.D.</i>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>9-15-84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>			ADDRESS <b>111 Penn Street, Balto., Md. 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>9/18/84</b>			23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEM.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO., MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1984</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
AGNES		BACKOF		SEPT. 6, 1984		12:18 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE	CAUCASION	6-25-01		83 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD.	U.S.A.			XXXXXX Baltimore County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON	STELLA MARIS HOSPICE		HOUSEWIFE		Own Home		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		
md		XXXX	BALTO		127 S. Potomac St		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
George Friedrich Telljohann		Catherine Christina Meyer		21206			
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
213-01-7430		Bernard H. Backof, 110 Chesley Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/6/84 to 9/6/84, that (I) (we) lost saw the deceased alive on 9/6/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Eddie Nakhuda MD						9-6-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
		Stella Maris/Dulaney Valley Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Sept. 10, 1984		Holy Redeemer		Baltimore MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214				SEP 11 1984		R. A. Altendall	



RECEIVED  
JAN 30 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

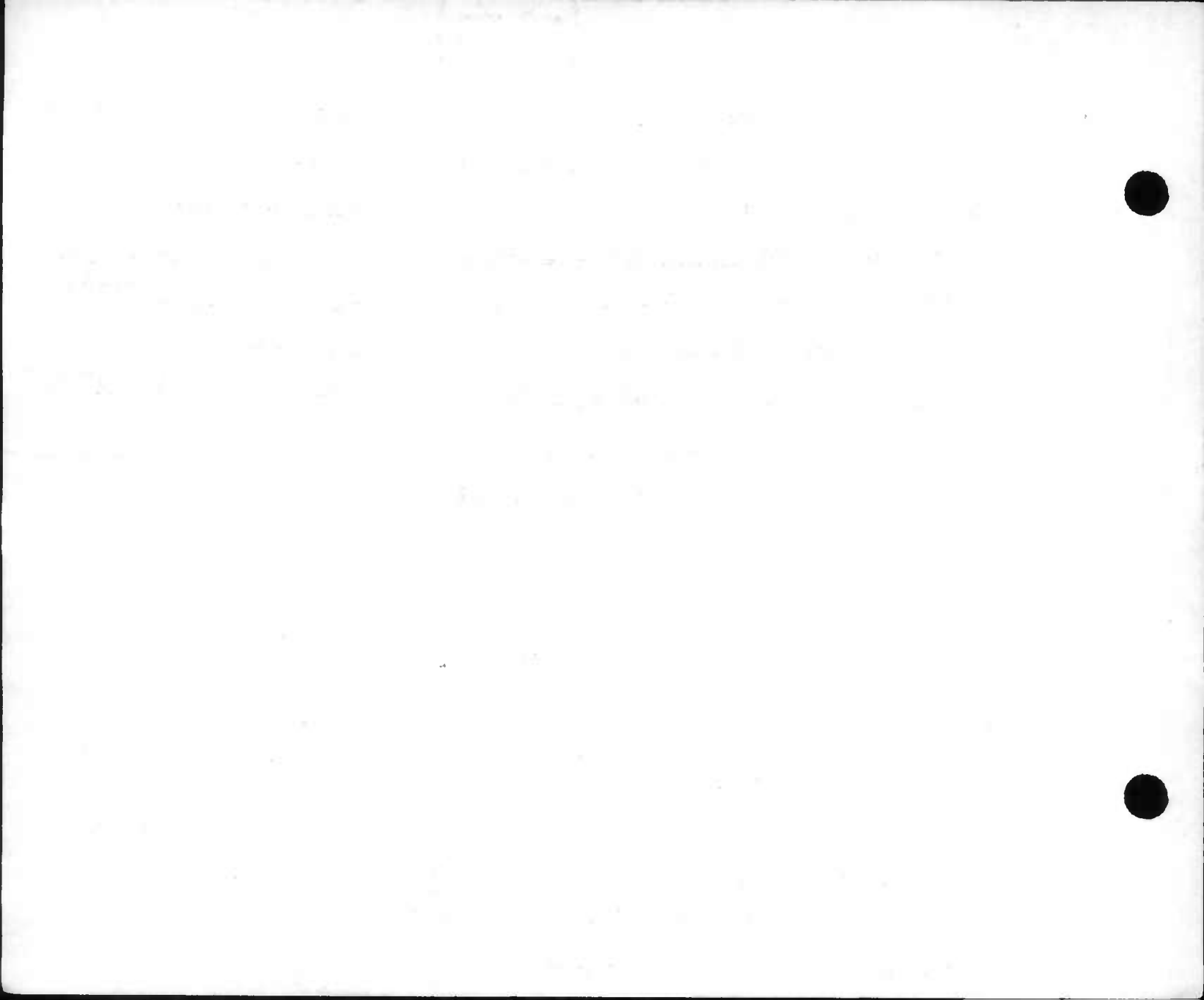
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 4 8 4

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Albert B. BAHLMAN				September 4, 1984				6:20 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M	W	3-2-1912		72 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	U.S.A.				Baltimore County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BALTO.	FRANKLIN SQUARE HOSP.		LONG SHOREMAN		DOCKWORK				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
MD.		BALTO.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3012 OAKCREST AVE.		21234			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
JOSEPH BAHLMAN		ANNA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
YES.		W.W.II		213-05-8983		Mrs. Clotha L. Long - 3012 Oakcrest Ave. 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Metastatic renal cell carcinoma</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>Sept. 4</u> 19 <u>84</u> to <u>Sept. 4</u> 19 <u>84</u> that (we) lost saw the deceased alive on <u>above</u> (we) (did) (did not) after death. 19 <u>84</u> and that in (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Dr. Frydenborg</u>		MD				9/4/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Dr. Frydenborg, MD		9000 Franklin Square DR., 21237							
22a. BURIAL, CREMATION, REMOVAL (SPECIFY)		22b. DATE		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION			
BURIAL		9-8-84		MORELAND MEM.		BALTO. MD.			
22a. FUNERAL DIRECTOR		22b. DATE REC'D. BY REGISTRAR		22c. REGISTRAR'S SIGNATURE					
<u>Harold P. Allen - 7527</u>		SEP 6 1984		<u>Julia Davidson-Russell</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

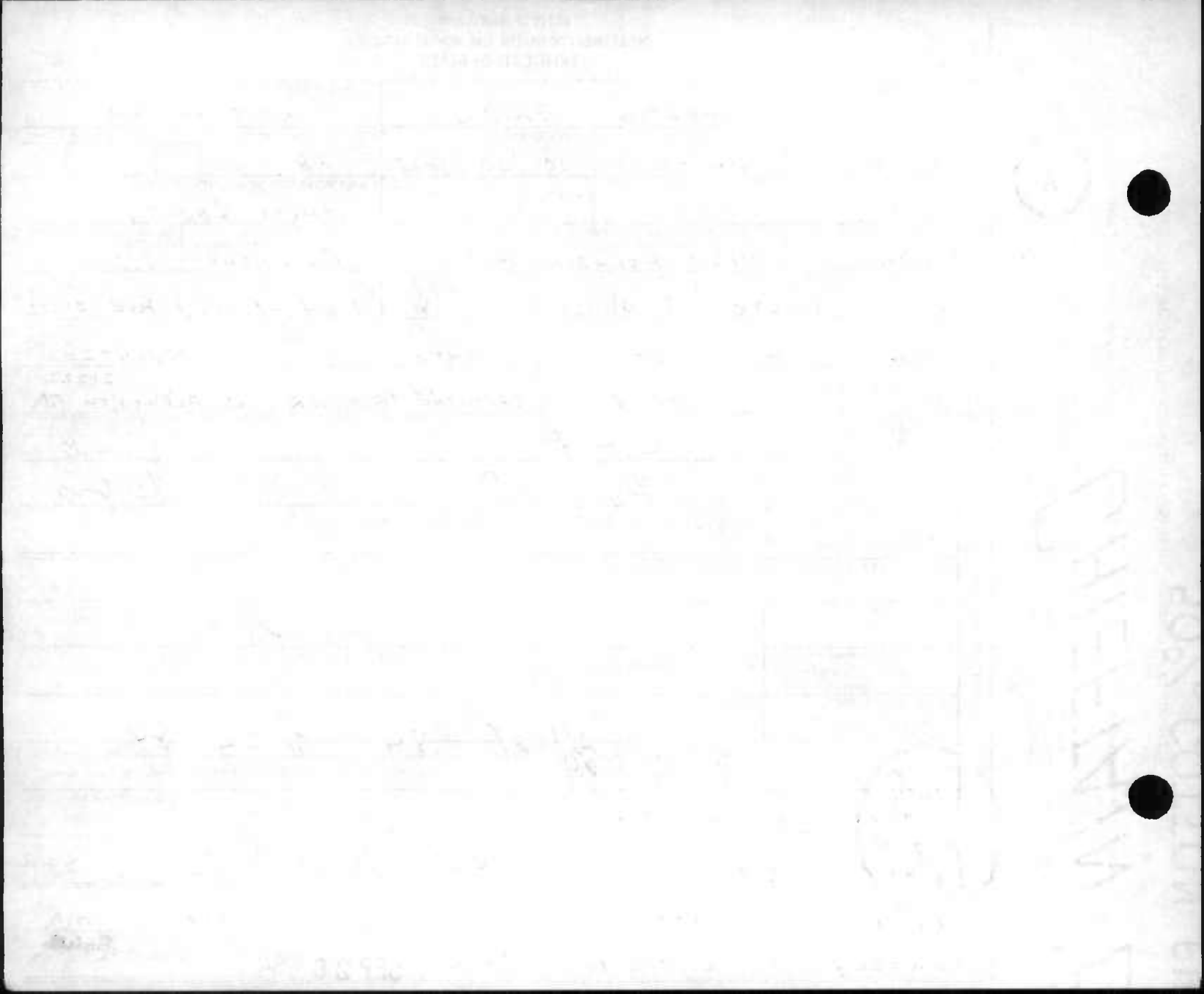
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 4 2 3 4 8 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN MARTIN BAIER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT 24 1984</b>		2b. HOUR <b>M</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 / 10 / 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>DUNDALK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7164 HOLABIRD AVE.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RAILROAD</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>
13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>DUNDALK</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN H. BAIER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATE HEINTZE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>705-10-9233</b>		17. INFORMANT ADDRESS <b>CAROLINE TRIMMER 765 ALDWORTH RD. 21222</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHF</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19 84</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/26/84</b> to <b>9/24/84</b> that (I) (we) last saw the deceased alive on <b>9/19/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John V. Connelly</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John V. Connelly</b>		22e. ADDRESS <b>3401 Dundalk Ave 21222</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>9/28/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DAK LAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>CONNELLY FUNERAL HOME OF DUNDALK</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 4 2 3 4 8 6							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST CLYDE EUGENE BALDWIN				September 29, 1984				M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 22, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Sparks		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14536 Bonnie View Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Building			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS 14536 Bonnie View Rd. 21152							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Sparks		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Owen Vernor Baldwin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sparks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT Bruce E. Baldwin, Sr. same as 13e.		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASEVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u> <u>15 yrs.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5/79</u> , 19____, to <u>9/79</u> , 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul J. Edgar</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>10/1/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul J. Edgar, M.D.				22e. ADDRESS 660 Kenilworth Drive							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-3-1984		23c. NAME OF CEMETERY OR CREMATORY Bosley United Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Sparks, Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.				ADDRESS 1050 York Road Towson, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 2 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

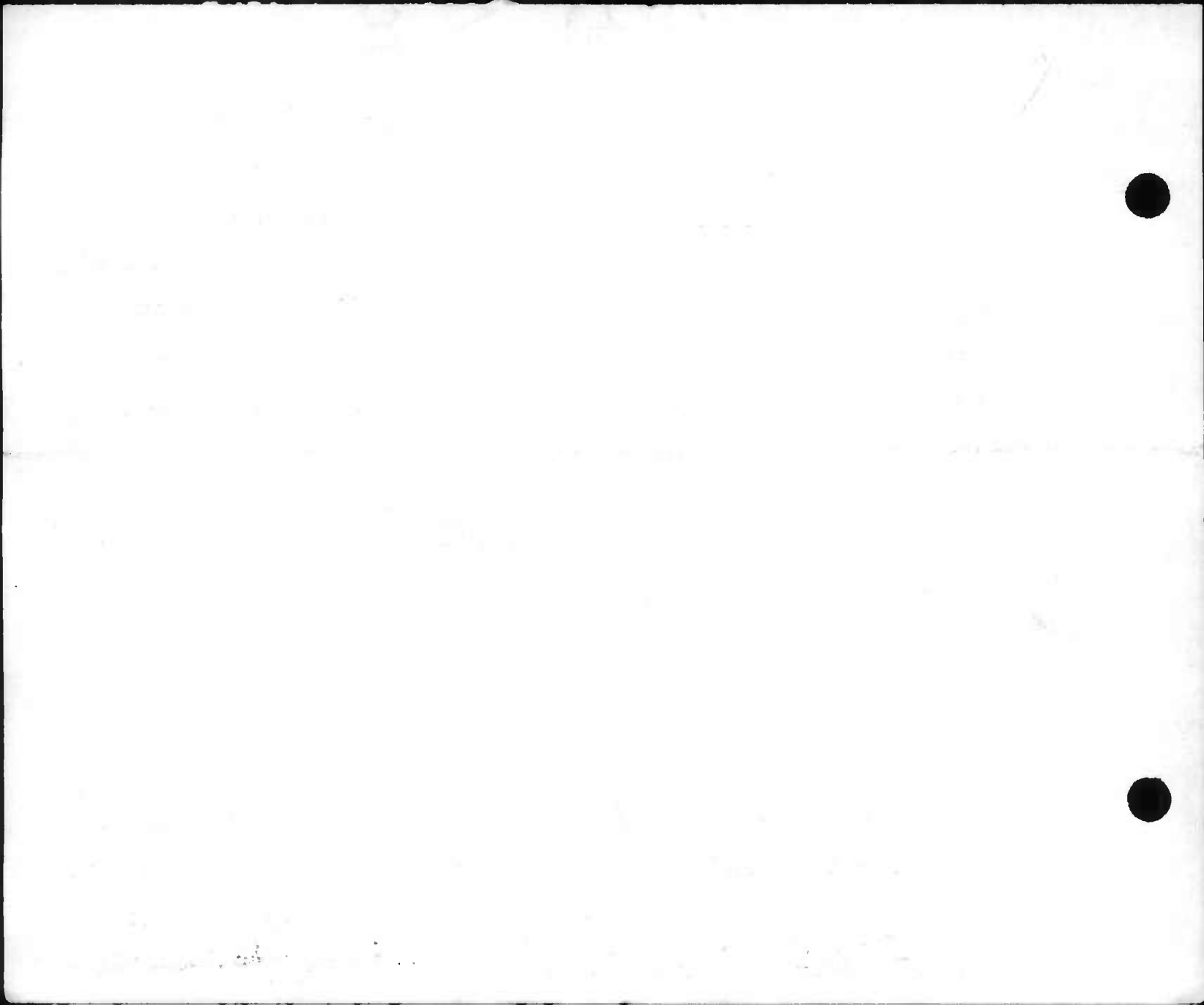
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			7b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ERNEST CHARLES BALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 8, 1984</b>			7b. HOUR <b>9:35 P M</b>		
3 SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 21, 1912</b>		
6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>72 YRS</b>			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PACKER</b>		
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		
13a. STATE <b>VIRGINIA</b>			13b. CITY OR TOWN <b>ALEXANDRIA</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLIE BALL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>INEZ PAYNE</b>			13d. STREET ADDRESS / ZIP CODE <b>710 1/2 Mt Vernon Avenue 99999</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WWII</b>			16b. SOCIAL SECURITY NO. <b>224 16 6614</b>			17. INFORMANT ADDRESS <b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF BLADDER</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ACUTE BILATERAL PYELONEPHRITIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA OF RIGHT LUNG</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>SEVERE RIGHT PLEURAL FIBROSES</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (his) hospital reported the deceased from <b>SEPTEMBER 8, 1984</b> to <b>SEPTEMBER 8, 1984</b> , that (I) (we) last saw the deceased alive on <b>SEPTEMBER 8, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Wen Shyang Wu</i>						DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9-10-84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WEN SHYANG WU, M.D.</b>						22e. ADDRESS <b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/12/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Comfort</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fairfax Co., Virginia</b>	
24. FUNERAL DIRECTOR NAME <i>David M. Kimmel</i> <b>Cunningham Funeral Home, Inc. Alex. Va.</b>						25a. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE <b>SEP 18 1984</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST SAMUEL BARBER		2a. DATE OF DEATH MONTH DAY YEAR 9 4 84		2b. HOUR 12-20 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 02 86		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AGENT		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE CITY MD BALTIMORE		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 5822 WESTERN					
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN BARBER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-09-4416		17. INFORMANT MRS. IRMA KNABLE APT. 302 7211 PARK HTS. AVE. BALTO., MD 21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. GENERAL ARTERIOSCLEROSIS.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-19 19 84, to 9-4 19 84, that (I) (we) last saw the deceased alive on 9-4 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Latneem Lachan		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/4/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LATNEEM LACHAN		22e. ADDRESS 5407 Old Court Rd, Randallstown							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		23e. DATE REC'D. BY REGISTRAR SEP 13 1984	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR SEP 13 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 4 2 3 4 8 9	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRA J. BARNES SR.					2a. DATE OF DEATH MONTH DAY YEAR 9-12-84			2b. HOUR 8:48 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 23 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 2 YEARS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3 Roosevelt Road 21784		
14. FATHER'S NAME FIRST MIDDLE LAST Ira Barnes					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hayman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-6836		17. INFORMANT ADDRESS Mrs. Emma Barnes - Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE HEART FAILURE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ISCHEMIC CARDIOMYOPATHY</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>9-12-84</u> to <u>9-12-84</u> , that (I) (we) last saw the deceased alive on <u>9-12-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-12-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. COMANAN M.D.					22e. ADDRESS BCH - RANDALLSTOWN Md. 21133						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 9/13/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25a. DATE RECD. BY REGISTRAR SEP 18 1984		25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

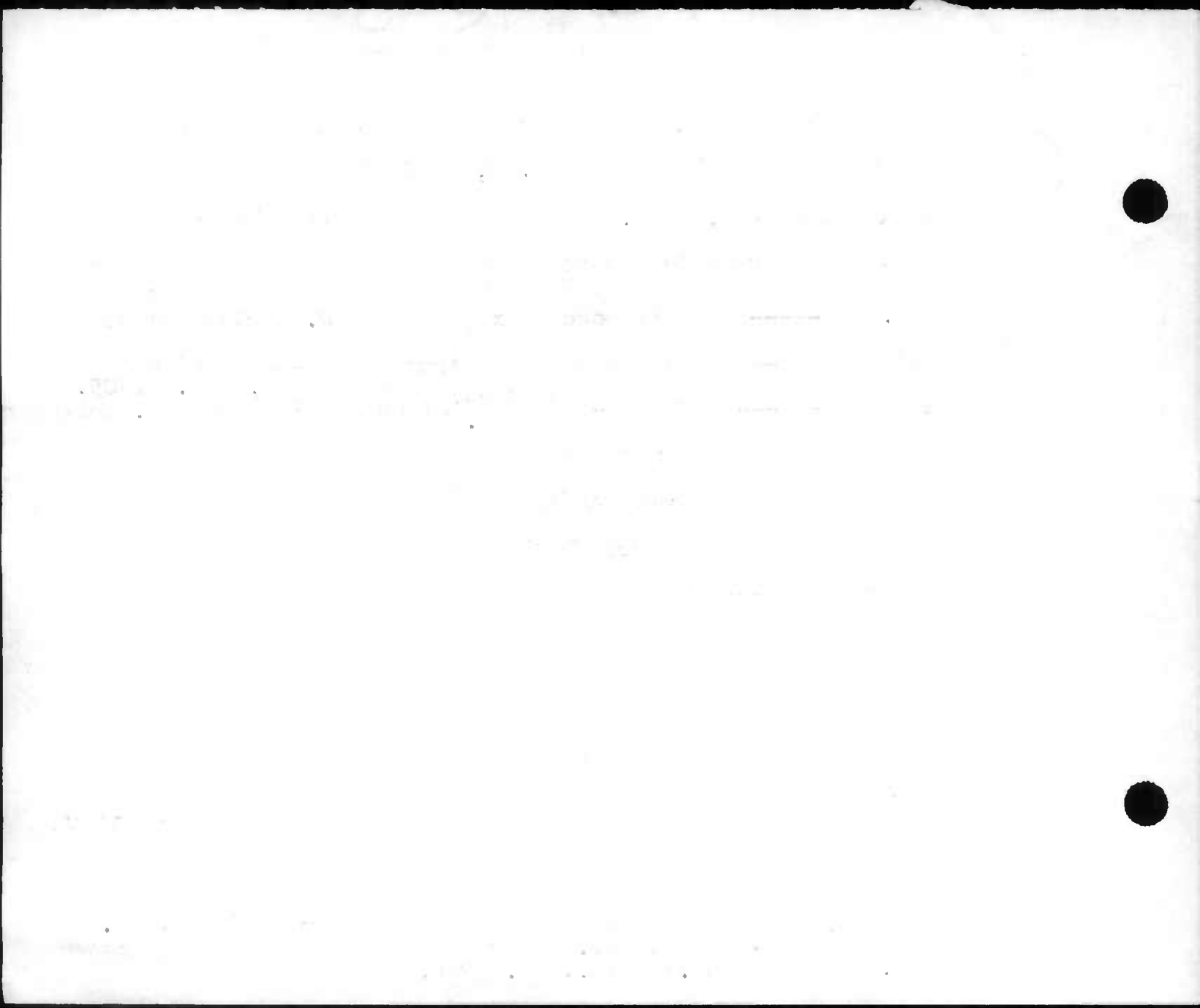
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
FIRST MIDDLE LAST Daisy A. BAROCH			MONTH DAY YEAR September 10, 1984			8:50 AM				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE			7. IF UNDER 1 YEAR				
Female	White	MONTH DAY YEAR Sept. 20, 1905	78 YRS			IF UNDER 24 HRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
North Carolina - U. S. A.			Baltimore County MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Rosedale	Franklin Square Hospital		Housewife			----				
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE				
Md.			Baltimore			21224-35 N. Curley Street				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST John --- McCotter			FIRST MIDDLE LAST Gertrude --- Delamar							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
No			215-01-6554			Niece: Linda Wilkinson-619 N. Robinson Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cardiac Arrest										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Hyponatremia										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Possible Sepsis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
Patient Comatose										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from September 7, 1984, to September 10, 1984, that (X) (we) lost the deceased alive on September 10, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			22b. SIGNATURE Dr. Alberto Borges, MD			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/10/84		
22e. ADDRESS 9000 Franklin Square Drive, 21237										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			9/12/84			Holy Redeemer Cemetery-Baltimore, Md.				
24. FUNERAL DIRECTOR			24b. ADDRESS			24c. DATE REC'D. BY REGISTRAR			24d. REGISTRAR'S SIGNATURE	
John A. Moran, Inc. Funeral Home			3000 E. Baltimore St.; Balto., Md. 21224			SEP 11 1984			John A. Moran	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Carrie Eva Bausch		Sept. 11 1984		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Jan. 16 1897		87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Valley Nursing and Convalescent Ctr.		Homemaker		-	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Lutherville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS			
John Ferdinand Westerkam		Mary Josephine Willinger		100 Hedgewood Rd., 21093			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		218-22-7512		Marie B. Starke, 100 Hedgewood Rd., 21093			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Many Years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> 19 <u>84</u> to <u>9/11</u> 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>8/31</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Hans J. Koetter</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Hans J. Koetter, M.D.		7600 Osler Dr., 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		9/14/84		Loudon Park Cem.		Baltimore City Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Martin D. Lawson				SEP 14 1984			
26. ADDRESS Martin D. Lawson, 10 W. Padonia Rd. 21093							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

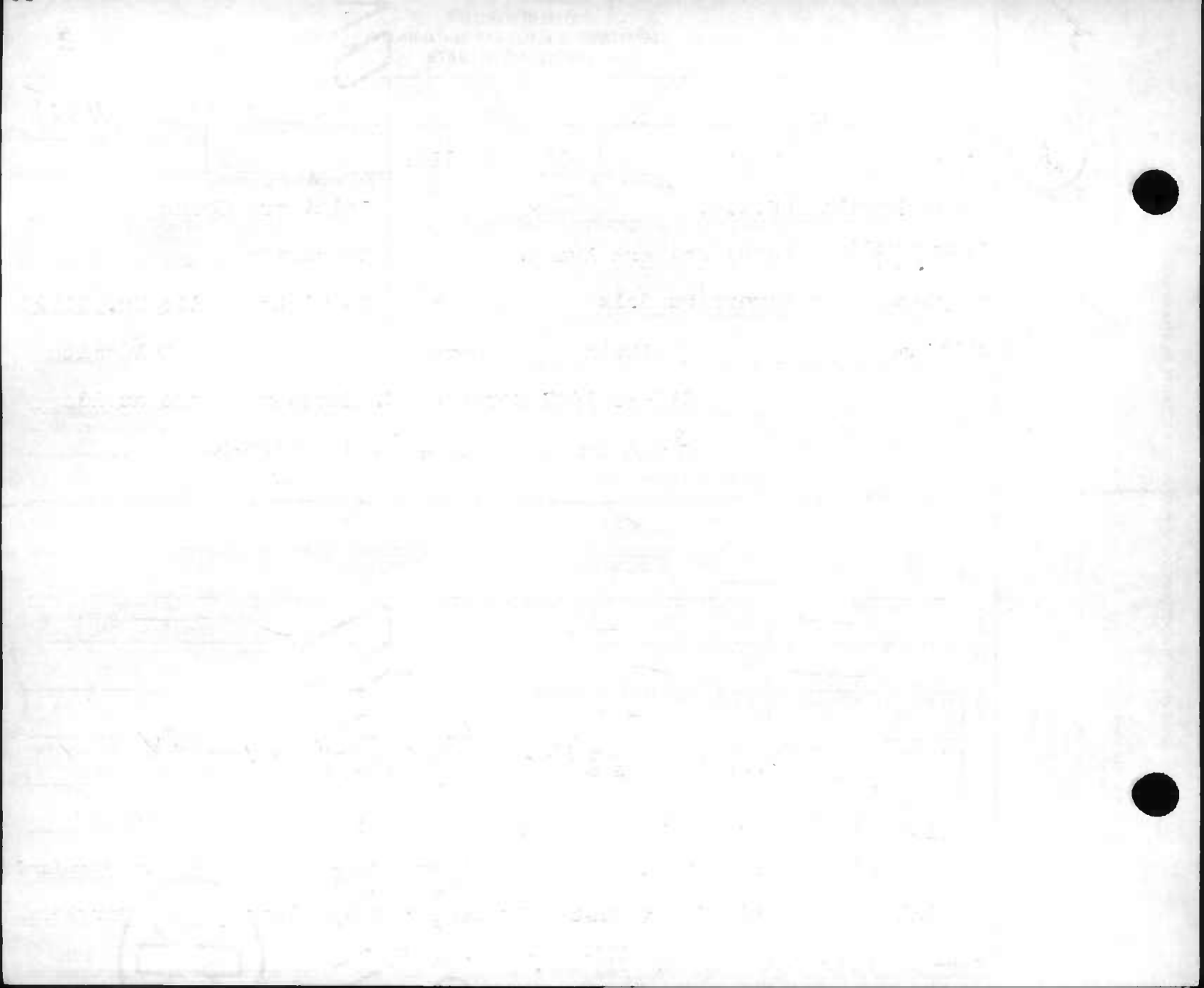
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HILDA C. BECK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 19 84</b>		2b. HOUR <b>11:00 P</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 7 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>85</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Hall</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4201 Halbert Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Pulkett</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Goldsmith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-30-1407</b>		17. INFORMANT ADDRESS <b>Dorothea K. Karcher Same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASACVD - CHF + Angina</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: _____							
19a. DATE OF OPERATION <b>3/23</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) _____			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> 19 <b>84</b> to <b>9/19</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/17</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Donald W. Mintzer, M.D.</b>				DEGREE <b>MD.</b>		22c. DATE SIGNED <b>9/20/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald W. Mintzer, M.D.</b>				22e. ADDRESS <b>3009 Evergreen Avenue Baltimore Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/22/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b>				ADDRESS <b>7922 Wise Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 24 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>Richard Randall</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
Mary A. Benson			9 27. 84			1:06 A.M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
F	White	Jan. 26 1903	81		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.			Baltimore Co. MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Randallstown	Baltimore Co. Gen. Hospital		School teacher		State Deaf School				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		13f. STREET ADDRESS / ZIP CODE	
Maryland		Carroll	Sykesville			Fairhaven, C-064, 72 3rd Avenue			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			
Harry G. Benson			Minnie			220-18-2219			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17b. SOCIAL SECURITY NO.			17c. INFORMANT			
No			220-18-2219			Rev. Fred P. Eckard, 1850 Old New Windsor Rd., New Windsor, Md. 21776			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) C. V. A.									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-27-84 to 9-27-84, that (I) (we) lost saw the deceased above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
RAY ADOR G. Rao.		M.D.				9/27/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
RAY ADOR G. Rao.		Balt. Co. General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Oct 1, 1984		Mt. Olivet Cemetery		Frederick Frederick Md			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			
Smith Keeney Basford B.A. Funeral Home		OCT 1 1984		Julia Davidson-Randall					
106 E. Church St., Frederick, Md. 21701									

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DWIGHT A. BERARD, SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/16/84</b>		7b. TIME <b>12:05AM</b>					
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 22, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N. CHARLES STREET-GBMC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. County</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2446 Lakewood Rd. 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Berard</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Harrison</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>027-07-5103</b>		17. INFORMANT ADDRESS <b>Lucille C. Berard - Same as #13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Large Cell CA of Unknown Primary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <i>[Signature]</i>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/16/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. T. HERLIHY, M.D.</b>			22e. ADDRESS <b>6701 N. CHARLES STREET-GBMC</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9-19-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium, Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>			ADDRESS <b>1050 York Rd. Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM H. BERIGTOLD</b>			2a. DATE OF DEATH MONTH <b>SEPTEMBER</b> DAY <b>12</b> YEAR <b>1984</b>		2b. HOUR <b>7:00a</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>6</b> DAY <b>19</b> YEAR <b>1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Parkville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8702 Stockwell Rd</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Postal Carrier</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Parkville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8702 Stockwell Rd. 21234</b>
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>Berigtold</b> (LAST) <b>Wilhelm</b>		15. MOTHER'S MARRIAGE NAME MIDDLE <b>Becker</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> <b>WWI</b>		16b. SOCIAL SECURITY NO. <b>217 38 0197</b>		17. INFORMANT ADDRESS <b>Alan E Berigtold 8702 Stockwell</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <b>Acute myocardial Ischemia with arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Arteriosclerotic Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <b>severe arrhythmia &amp; pacemaker</b> <b>and chronic heart failure</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 76</b> to <b>Sept 84</b> , that (I) <b>no</b> lost saw the deceased alive on <b>July 84</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above (do not sign if you did not view the body after death).					
22b. SIGNATURE <b>Frank T. Kasik Jr MD</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/12/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANK T. KASIK JR MD</b>		22e. ADDRESS <b>9005 HARFORD PL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 15, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>	
23d. LOCATION CITY OR TOWN <b>Timonium</b> COUNTY <b>Balto</b> STATE <b>Md.</b>		24. DIRECTOR'S SIGNATURE <b>ROBERT G. ALTENBURG FUNERAL HOME, INC.</b> <b>6009 Harford Rd.</b> <b>Balto., Md. 21214</b>			
25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

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*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 4 9 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

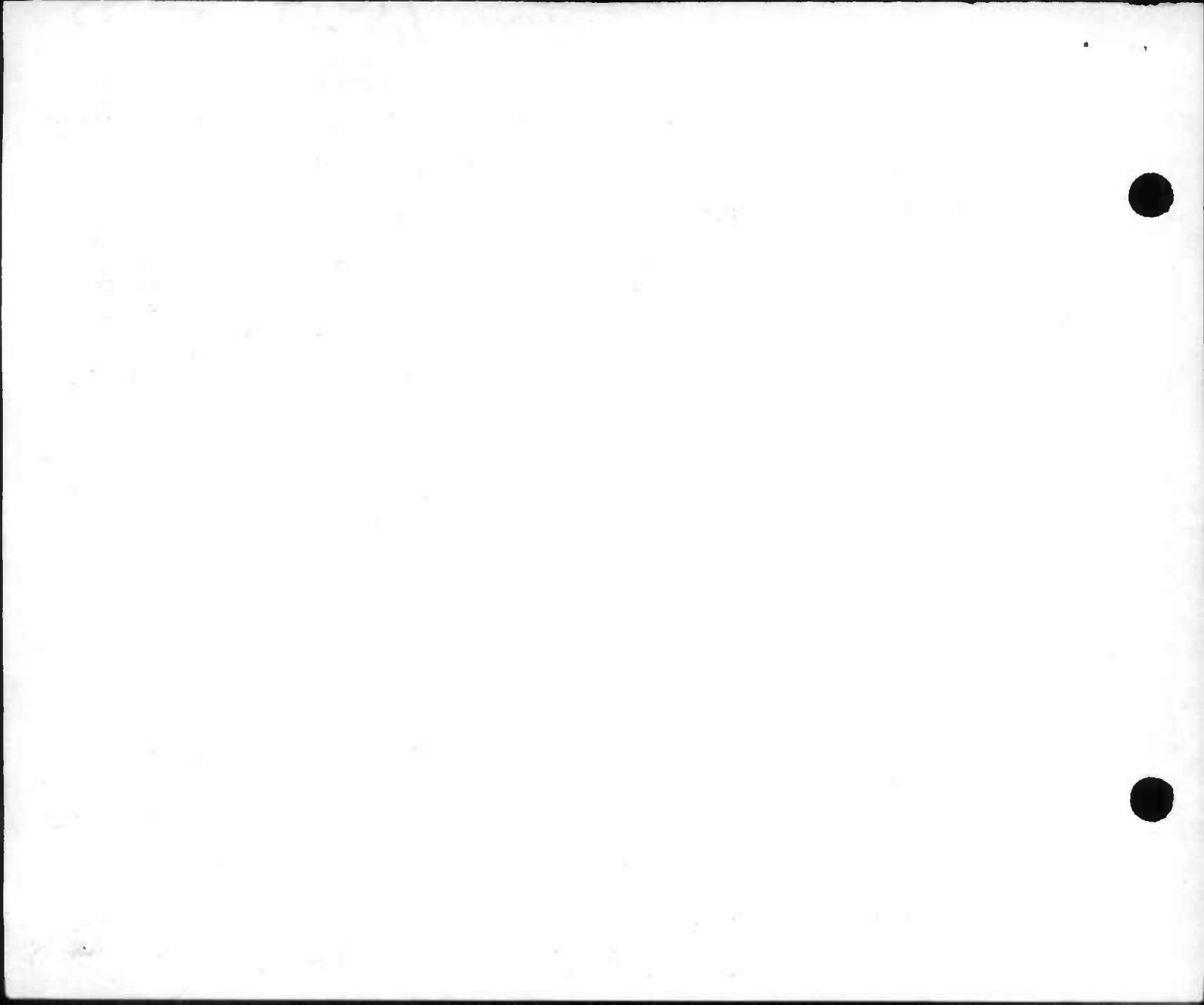
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEWIS E. BERLIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 13 84</b>		2b. HOUR <b>8.45 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 - 28 - 05</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>79</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>RandallsTown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>SHOES</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENTIAL ADDRESS) 13a. STATE <b>MD</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>5412 1st St. S. 2122</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WOLFF BERLIN</b>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE PUGATCH</b>		16. SOCIAL SECURITY NO. <b>577-07-5952</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	17. INFORMANT <b>HARRY BERLIN</b>		17. ADDRESS <b>229-12 87th AVE. QUEENS VILLAGE, NY 11427</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Diffuse Cerebral Damage</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypotension &amp; upper GI Bleeding</b>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>9/13</b> , 19 <b>84</b> , to <b>9/13</b> , 19 <b>84</b> , that (we) last saw the deceased alive on <b>9/13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Young J. Ro</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>9/13/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Young Joon Ro</b>		22e. ADDRESS <b>B. C. G. H.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>SEPT. 14, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WORKMEN CIRCLE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1984</b>		
25b. ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			25c. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 4 9 7

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Cora Mae Birmingham</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 25, 1984</b>				2b. HOUR <b>M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 2, 1923</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>61</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Co., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10 CITY OR TOWN OF DEATH <b>Middle River</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>405 Carrollwood Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assembler</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Western Elec.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Middle River</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Parlett</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Dobson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17 INFORMANT ADDRESS <b>Louis T. Birmingham, Husband</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alberto Sant Antonio MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9/25/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERTO SANT ANTONIO</b>				22e. ADDRESS <b>1204 CHESAPEAKE AVE</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>9/28/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 23498							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Davis N. Bishop</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 4 1984</b>		2b. HOUR <b>M</b>			
3. SEX <b>male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 23 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1103 Ryegate Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pharmacist Rt.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pharmacy</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1103 Ryegate Road 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nelson Bishop</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Morris</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-05-1985</b>		17. INFORMANT ADDRESS <b>Mrs. Lillian Bishop Towson, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Vertebral Artery</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James C. Ricely</b>				22c. DATE SIGNED <b>9/4/84</b>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James C. Ricely MD.</b>	
22e. ADDRESS <b>Greater Baltimore Med. Center, Balt. Md.</b>				22f. DATE REC'D. BY REGISTRAR 22g. REGISTRAR'S SIGNATURE <b>[Signature]</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-7-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro Caroline Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John E. Boulais</b>				24b. ADDRESS <b>P.O. Box 160 Greensboro, Md.</b>		24c. DATE REC'D. BY REGISTRAR 24d. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-4 23492 1132R7

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
VERA I. BISHOP				September 22, 1984 7:45 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR
Female	White	MONTH DAY YEAR	95 YRS	MONTHS DAYS	HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD	USA			Baltimore County MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Ruxton	Manor Care Ruxton		Homemaker		Own Home
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD		Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1544 Sheffield Rd., 21218	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
George Burrall		(Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		214 07 0294	Mrs. Ruth L. Pindell, Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <i>acute myocardial infarction</i>					<i>sudden</i>
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					<i>5 days</i>
(b) <i>ASCD</i>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			CITY OR TOWN COUNTY STATE		
22a. I certify that (s) (his) hospital attended the deceased from 19 <i>82</i> to <i>9/22</i> 19 <i>84</i> that (s) (we) lost saw the deceased alive on <i>Sept 17 82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>Dr. William F. Renner</i>		<i>M.D.</i>		<i>9/24/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dr. William F. Renner, M.D.		3222 St. Paul St., Balto., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	9/25/84	Moreland Memorial	Balto. County, MD		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
Henry W. Jenkins & Sons Co.		SEP 25 1984		<i>Galia Burden-Rendell</i>	
4905 York Road Balto., MD 21212					

35 90 35 300 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.



1. The first part of the report is a general statement of the purpose and scope of the study. This is followed by a brief review of the literature on the subject. The third part of the report is a description of the methods used in the study. This is followed by a presentation of the results of the study. The final part of the report is a discussion of the results and their implications.

2. The second part of the report is a detailed description of the methods used in the study. This includes a description of the subjects, the materials, and the procedures used. This is followed by a presentation of the results of the study. The final part of the report is a discussion of the results and their implications.

3. The third part of the report is a discussion of the results and their implications. This includes a discussion of the strengths and weaknesses of the study, and a discussion of the implications of the results for future research. The final part of the report is a conclusion.

4. The fourth part of the report is a conclusion. This includes a summary of the findings of the study, and a statement of the conclusions drawn from the findings. The final part of the report is a list of references.

5. The fifth part of the report is a list of references. This includes a list of the books, articles, and other sources used in the study. The final part of the report is a list of appendices.

6. The sixth part of the report is a list of appendices. This includes a list of the tables, figures, and other materials used in the study. The final part of the report is a list of footnotes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.5+  
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 4 2 3 5 0 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM R. BISHOP			2a. DATE OF DEATH MONTH DAY YEAR Sept. 9 1984		2b. HOUR 10:30 AM	
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 01 07 01		
6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9b. CITIZEN OF WHAT COUNTRY? U.S.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center Catonsville		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		
12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 608 Pontiac Ave. 21225		14. FATHER'S NAME FIRST MIDDLE LAST Tasac Bishop		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Martin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 190-05-4775		
17. INFORMANT Mrs. Mabel Esworthy 284 Stanley Terr. 21225		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARDS, CVA A.S.C.V.D., CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>9-6-84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE X <u>George Angrov</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-11-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George Angrov		22e. ADDRESS 5404 Port Drive 3350 Wilkens Ave. Baltimore Md 21227				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/12/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. A.A. Md.		24. FUNERAL DIRECTOR McULLy Funeral Home 237 E. patapsco Ave.				
25a. DATE REC'D. BY REGISTRAR SEP 13 1984		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall				

BP

100-100000

(Pneumonia)

A.S.C.V.D., CVA

**NOTE TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE SIGN AND DATE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGE 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH PCQM PM 3. RETAIN PAGE 5 WITH YOUR FILES. **NOTE TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS OF DEATH. DIVISION OF VITAL RECORDS - 601 N. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										23501 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAE E. BLAIR										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 23 1984		2b. HOUR M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 5/31/18		6. AGE (IN YEARS) (LAST BIRTHDAY) 66 YRS.	7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 24 1984		2d. HOUR 1:35 A M	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) N. J.		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH MIDDLE RIVER		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7308 Greenbank Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSLWE		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE M.D.										13b. COUNTY BALTO.		13c. CITY OR TOWN MIDDLE RIVER
14. FATHER'S NAME FIRST MIDDLE LAST H. J. WITTHAUER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK			13d. STREET ADDRESS 21220 GREENBANK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 21501 7339		17. INFORMANT BERNADINE ROBL			ADDRESS 8016 BANK ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 9-24-84				
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/26/84		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.				
24. FUNERAL DIRECTOR NAME J. G. CONNELLY						ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR SEP 26 1984		25b. REGISTRAR'S SIGNATURE Lila Davidson-Rendall		



STATE OF NEW YORK  
IN SENATE  
January 13, 1910  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1909  
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS  
1910





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 5 0 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RAYMOND D BLAKESLEE			2a. DATE OF DEATH MONTH DAY YEAR SEPT 10 1984			2b. HOUR 10:55 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 16 26		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Co., MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Aircraft	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8326 Kendale Road 21234	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN 21234			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur L. Blakeslee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Morrison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 719-10-6729		17. INFORMANT ADDRESS Margaret S. Blakeslee 8326 Kendale Rd. 21234			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE WITH

CARDIAC ARREST

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

5 MIN.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

GASTROINTESTINAL BLEEDING ACUTE PROBABLY DUODENAL ULCER

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22. I certify that (I) (this hospital) attended the deceased from SEPT 10 19 84 to SEPT 10 19 84 that (I) (we) last saw the deceased alive on SEPT 10 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

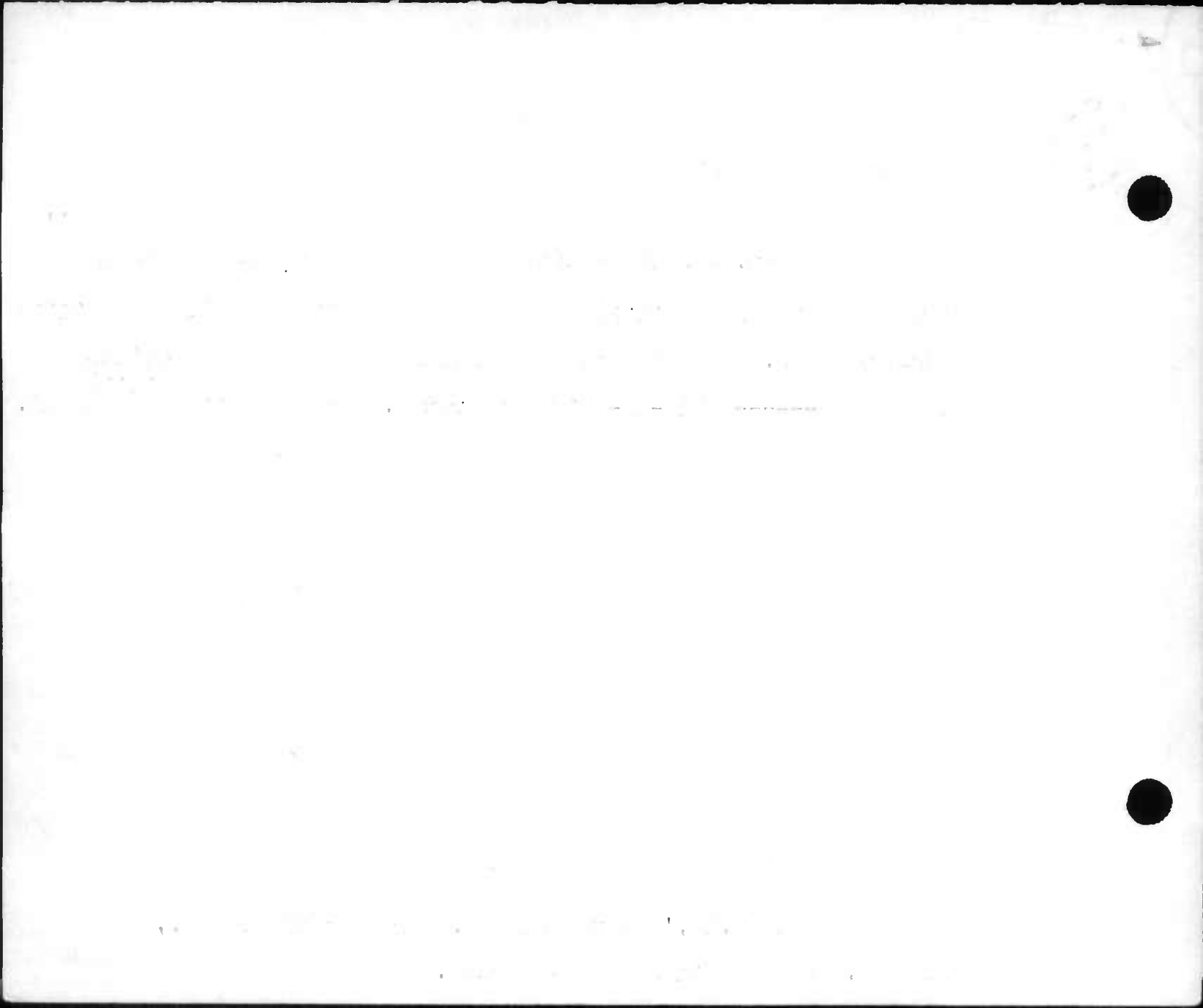
22b. SIGNATURE Samuel O'Mansky		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept 10 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL O'MANSKY		22e. ADDRESS 8405A LOCHRAVEN BLVD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 13, '84		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD	
24. FUNERAL DIRECTOR NAME William E. Johnson				ADDRESS 8521 Loch Raven Blvd.		25a. DATE REC'D. BY REGISTRAR SEP 13 1984	
						25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retention by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

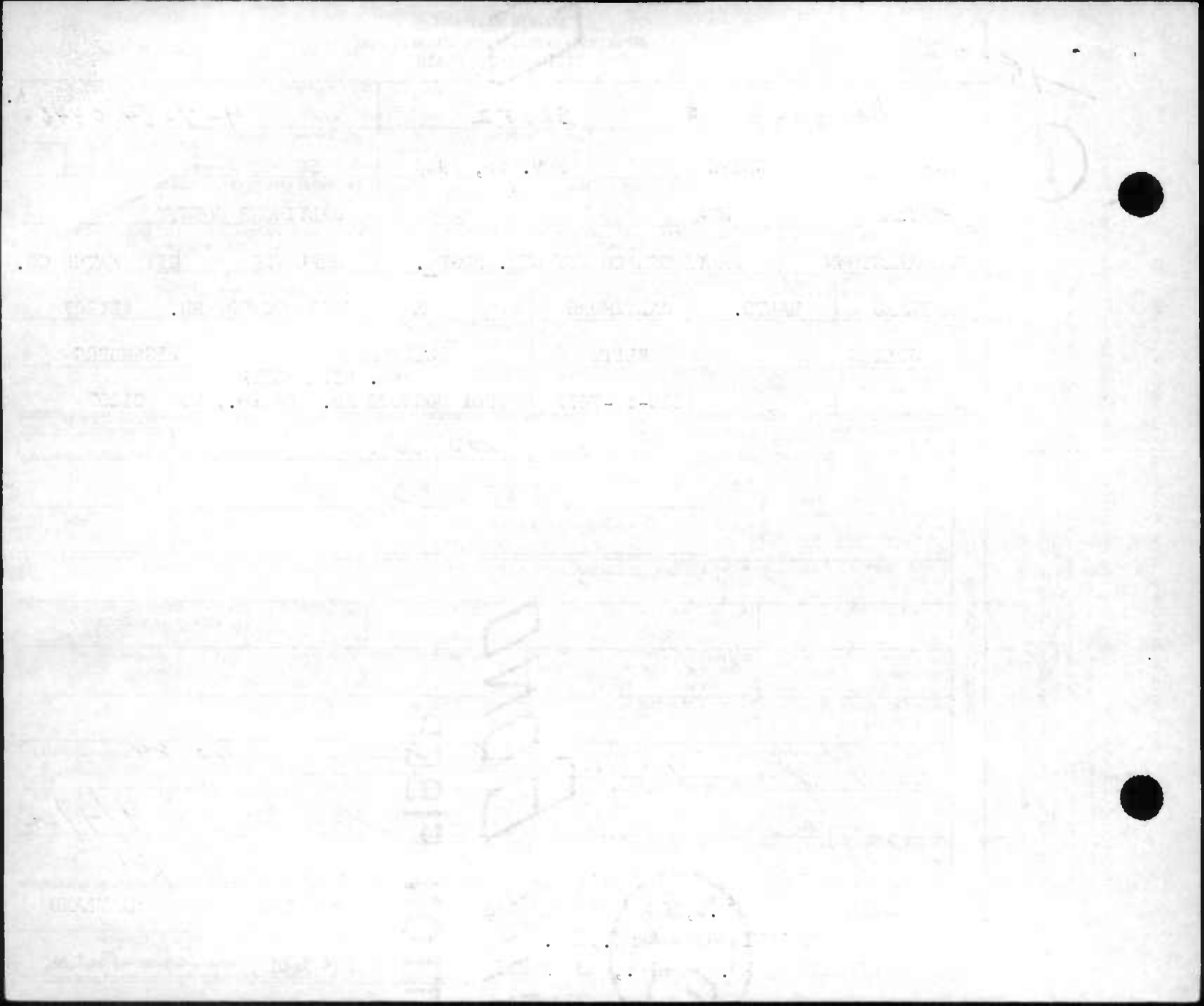
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

4 23503

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BERNARD R BLITZ</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9-7-84</b>		2b. HOUR <b>0446 M</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 16, 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EMPLOYEE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CITY WATER CO.</b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>8501 DOGWOOD RD. #21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JULIUS BLITZ</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH EISENBERG</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-18-7677</b>		17. INFORMANT <b>MRS. RITA BLITZ</b> <b>8501 DOGWOOD RD. BALTO., MD 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute M.I.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/7 1984 P.M.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/19/81</b> to <b>9/7/84</b> , that (I) (we) last saw the deceased alive on <b>9/7/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jerome J. Collier MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/7/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jerome J. Collier MD</b>		22e. ADDRESS <b>600 Reisterstown Rd</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>SEPT. 9, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>	
23d. LOCATION <b>BALTIMORE</b>		COUNTY <b>MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 4 2 3 5 0 4			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jessie Irene BOBLITS						2a. DATE OF DEATH MONTH DAY YEAR September 11, 1984				2b. HOUR 6:10 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 17 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) Franklin Sq. Hospital				12a. USUAL OCCUPATION (TYPE OR NATURE OF WORKING LIFE) Assembler		12b. KIND OF BUSINESS OR Martin Co.			
USUAL RESIDENCE (If nursing home or other institution, give residence before admission) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Essex						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 37 Langley Rd. 21221			
14. FATHER'S NAME FIRST MIDDLE LAST Ira E. Carey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Griffin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Jesse C. Boblits		5428 Moores Run Dr. Balto., Md. 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: inline-block; vertical-align: middle; font-size: 3em; margin: 0 10px;">}</div> DUE TO, OR AS A CONSEQUENCE OF (b) Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Cardiogenic Shock											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 30, 1984, to September 11, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on September 11, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. I. Rodriguez, MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-11-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. I. Rodriguez, MD						22e. ADDRESS 9000 Franklin Square Drive, 21237					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9/15/84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION Baltimore Co., Md. STATE					
24. FUNERAL DIRECTOR Boudzinski Funeral Home PA 1407 Old Eastern Ave						25a. DATE REC'D. BY REGISTRAR SEP 13 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

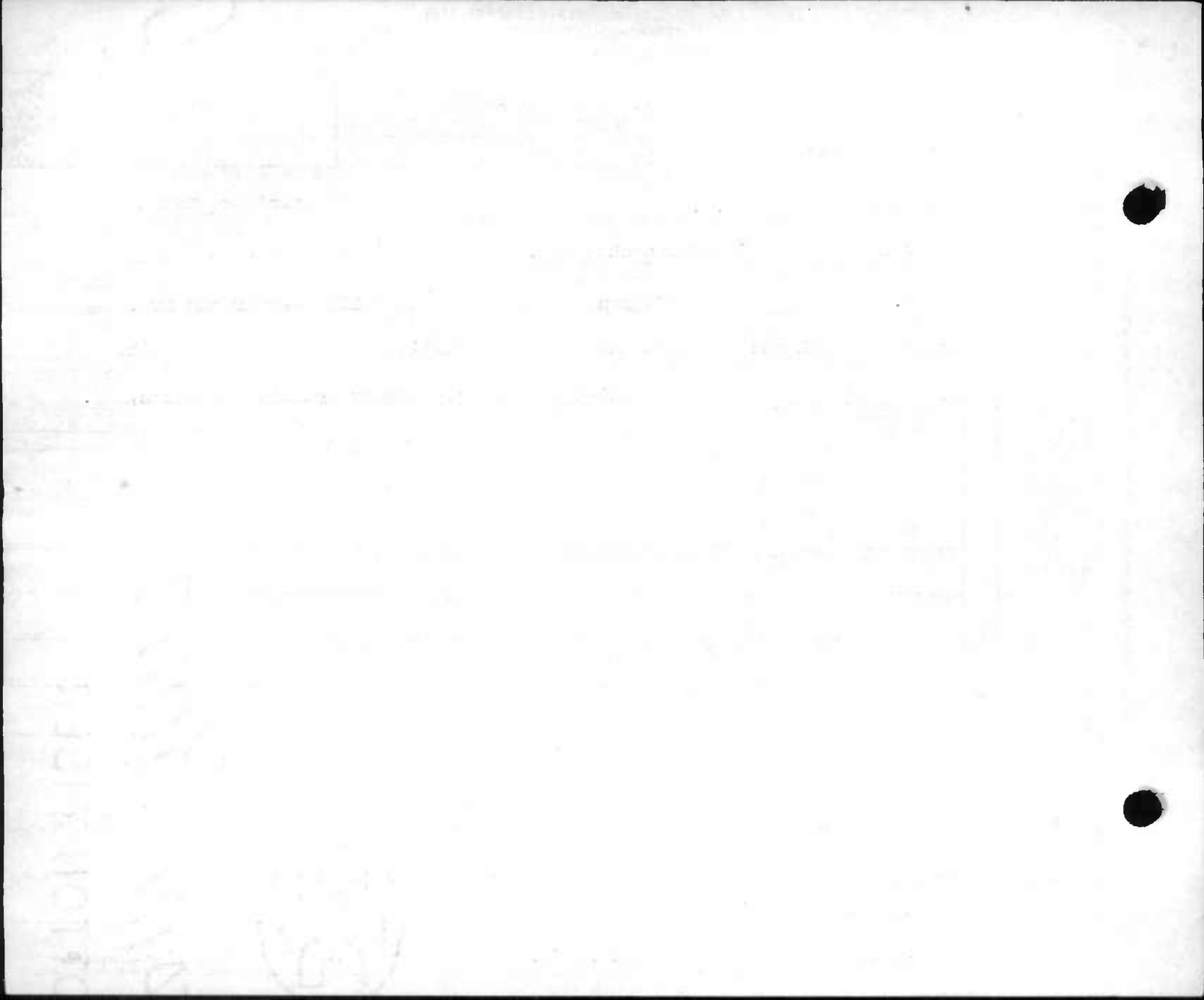
BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 3 5 0 5  
REG. NO.

1- STATE REGISTRAR		FOR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE
ELEANOR		E.	BONORDEN
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY)
Female	White	2 13 17	67 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Maryland		U.S.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Towson		1315 Margarette Ave.	Homemaker
13a. STATE		13b. COUNTY	13c. CITY OR TOWN
Md.			Towson
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
		1315 Margarette Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Thomas Talbott Eubank		Pauline White	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No		055-10-2019	
17. INFORMANT		ADDRESS	
Ms. Eleanor Brundick Crofton, Md.		2054 Lake Grove	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordian Artery</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary of Heart</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. <u>5+ yrs</u> (b) <u>5+ yrs</u> (c) <u>5+ yrs</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charlotte McDonnell</u>		TITLE (SPECIFY) <u>Deputy</u>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Removal		9/12/84	
24. FUNERAL DIRECTOR NAME		23c. NAME OF CEMETERY OR CREMATORY	
Anatomy Board		Balto., Md.	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SEP 13 1984		Julia Davidson-Randall	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH HIS FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMM - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23506  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Ronald Botsch					DATE MATED	9	14	1984	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	White	May 19, 1944	40 YRS.			9-15 1984				1:55 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	U.S.A.				Baltimore County, MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Woodlawn, Baltimore	1725 C Champlain		Restaurant Supervisor								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS							
Maryland	Baltimore	Baltimore		1725 C Champlain Dr 21207							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
William Andrew Botsch			Jessie Gertrude Waxter								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		219-40-5363		Mrs Jessie G Canapp 5810 Edgemark Rd							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED					
Dennis F. Smyth, M.D.		M.D. Assistant				9-16-84					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Entombment		9/19/84		Gardens Of Faith		Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		THE REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc.		Baltimore, Maryland				SEP 17 1984					

MEDICAL CERTIFICATION



Handwritten text at the bottom left corner, possibly a signature or date, appearing as "1944" or similar.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 5 0 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary M. BOWINGS				2a. DATE OF DEATH MONTH DAY YEAR September 28, 1984				2b. HOUR 5:18P M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12/19/09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSEW		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 200 S. MARLYN 21221	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE J. PIERCE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH E. BROWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 21534 6810		17. INFORMANT ADDRESS FRANK BOWINGS SR.			A ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Sepsis Shock</u> (b) DUE TO, OR AS A CONSEQUENCE OF <u>Infected Left Groin</u> (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 26</u> , 19 <u>84</u> , to <u>September 28</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 28</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (and we) (find) the body after death.									
22b. SIGNATURE <u>Jagiello</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ben Jagiello, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/1/84		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME J.G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR OCT 3 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Randall	

MEDICAL CERTIFICATION

2  
9

1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 0 8

FOR  
1- STATE  
REGISTRAR

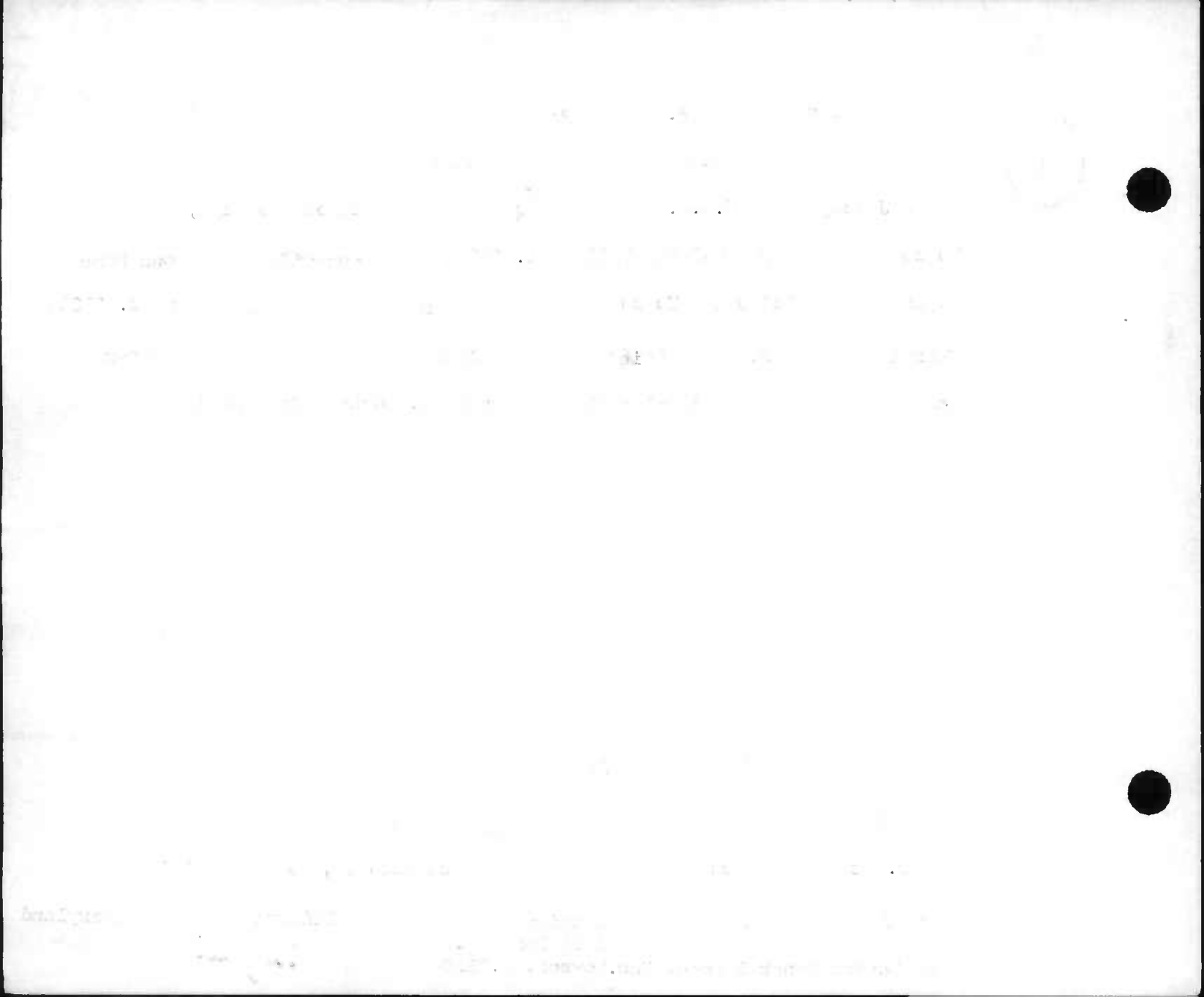
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Grace A. Boyle</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 26 84</b>			2b. HOUR M <b>AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 8 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>906 Dulaney Valley Ct. 21204</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>906 Dulaney Valley Ct. 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George J. Stieh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Baxter</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>144-28-5563</b>			17. INFORMANT ADDRESS <b>Edward B. Boyle - Same as #13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NOT A STATIC LONG PA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7</b> 19 <b>84</b> to <b>personal</b> 19 <b>84</b> . saw the deceased alive on <b>7</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen Glasser</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/26/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Stephen Glasser</b>						22e. ADDRESS <b>600 Reisterstown, Road 21208</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>9-29-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 27 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson Handell</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Thomas E Boyle</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>9 26 1984</u>			2b. HOUR <u>4:40AM</u>	
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>10 07 1923</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>60</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County MD.</u>	
10. CITY OR TOWN OF DEATH <u>Randallstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore County General</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Supervisor University of MD.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Balto. County</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Pikesville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Garrison T. Boyle</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Katherine Young</u>		13e. STREET ADDRESS / ZIP CODE <u>20 Stockmill RD 21208</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <u>Yes WW II</u>		16b. SOCIAL SECURITY NO. <u>216-12-2204</u>		17. INFORMANT NAME ADDRESS <u>Mrs. Ingrid L. Boyle 21208</u>		20 Stockmill Road Apt. B Pikesville, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Brainstem C.V.A.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Approximate interval between onset and death <u>7 1/2 hours</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>Diabetes Mellitus A.S.C. Arteriovascular Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9-25</u> , 19 <u>84</u> , to <u>9-26</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>9-26</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William J. Chircus M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>9-26-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William J. Chircus M.D.</u>				22e. ADDRESS <u>32 Stockmill RD Apt K 21208</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>9/29/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Pikesville Baltimore MD.</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133</u>				25a. DATE REC'D. BY REGISTRAR <u>SEP 28 1984</u>			
				25b. REGISTRAR'S SIGNATURE <u>Gina Davidson-Randall</u>			

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

6 4 2 3 5 1 0

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) PEARL PEARL		MIDDLE BRAUDES BRAUDES		LAST BRAUDES BRAUDES		2a. DATE OF DEATH MONTH DAY YEAR 09 19 84		2b. HOUR 930A.M.	
3. SEX FEMALE F		4. RACE WHITE W		5. DATE OF BIRTH MONTH DAY YEAR FEB. 11, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CO. GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4782 BYRON RD. #21208	
14. FATHER'S NAME FIRST SAMUEL MIDDLE LAST COHEN		15. MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE LAST ROSS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-32-6560D		17. INFORMANT MR. ALVIN R. BRAUDES ADDRESS 8419 WILLOW OAK RD. BALTO., MD 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute cardiac decompensation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/12</u> 19 <u>84</u> to <u>9/19</u> 19 <u>84</u> , that (we) last saw the deceased alive on <u>9/19</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S. Milner</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>9/19/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. MILNER</u>		22e. ADDRESS <u>5400 Old Court Rd</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/20/84		23c. NAME OF CEMETERY OR CREMATORY HAR ZION TIFERETH ISRAEL		23d. LOCATION ROSEDALE		23e. BALTO. MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR SEP 25 1984		25b. REGISTRAR'S SIGNATURE <u>S. Milner</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



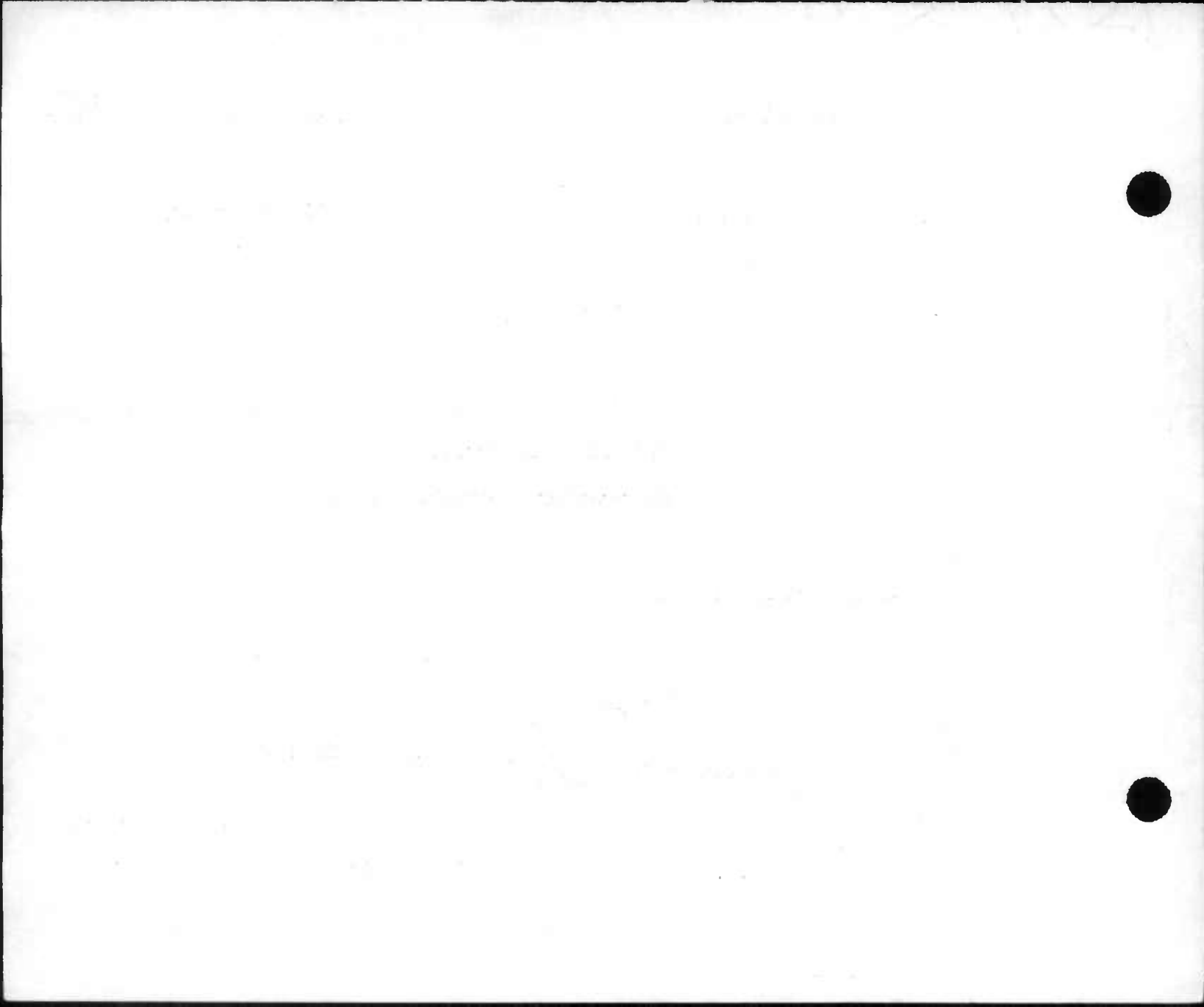
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Genevieve BRAUER</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>September 8, 1984</b>		2b. HOUR <b>1:10 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24, 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>							
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Rossville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3511 Glenmore Ave. 21206</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Burke</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lenora Tolson</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213-28-3582</b>		17. INFORMANT ADDRESS <b>William Brauer same as 13 e</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Acute Anterior Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Carotid Artery Stenosis</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 15, 1984</b> to <b>September 8, 1984</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 8, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.													
22b. SIGNATURE <b>K. Mason, MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>9/8/84</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Karen Mason, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/11/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>							
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>				ADDRESS <b>5305 Harford Rd. 21214</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Swickard-Randell</b>					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

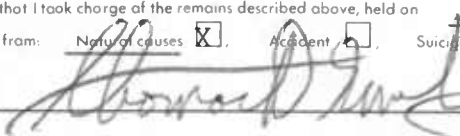

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23512			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Bertha Z. Braun				2b. HOUR AM 5:55			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6 18 94		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 103 Shady Nook Ct. 21228		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Resident Dir.		12b. KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13e. STREET ADDRESS 103 Shady Nook Ct. 21228	
14. FATHER'S NAME FIRST MIDDLE LAST William Zeilmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Hinkle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-36-7074		17. INFORMANT ADDRESS Norma W. Files 9101 Waycross Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cerebrovascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>heart disease</u>				APPROXIMATE PERIOD BETWEEN ONSET AND DEATH 6 wks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>nephrosclerosis diabetes m.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-28</u> , 19 <u>84</u> , to <u>9-25</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8-28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. Bradley Daugharthy</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Bradley Daugharthy, M.D.		22e. ADDRESS 1264 Francis Ave. Balto., Md. 21227					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-28-84		23c. NAME OF CEMETERY OR CREMATORY Forest Baptist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Pa.	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville, Md		25a. DATE REC'D. BY REGISTRAR SEP 27 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendall</u>	



200-500-0000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
FIRST MIDDLE LAST Reuben James Briggs						9 22 1984		9 22 1984		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male		White		Nov. 24, 1971		12 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Maryland				U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Randallstown				3718 Valley Hill Drive				None			
12b. KIND OF BUSINESS OR INDUSTRY											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. ZIP CODE	
Md.		Carroll		Manchester		YES <input type="checkbox"/> NO <input type="checkbox"/>		2909 Michelle Road		21102	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST James Larry Briggs						FIRST MIDDLE LAST Laura Lou Free					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT			
No				220-88-7727				2909 Michelle Road, James L. Briggs Manchester, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Seizure disorder</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
								CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
				Deputy Chief				9/23/84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Thomas D. Smith, M.D.				111 Penn St.				Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Burial				Sept. 25, 1984		New Manchester Cemetery				Manchester, Carroll, Md.	
24. FUNERAL DIRECTOR				25a. DATE OF DEATH				25b. REGISTRAR			
				Manchester, Maryland				SEP 23 1984			

BP

15 JUL 1951

Memorandum

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6  
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sophie Edith Brody</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9/5/84</i>		2b. HOUR <i>4:17 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 20 1888</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>96</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County MD.</i>	
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Stella Maris Hospice</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Towson</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jacob Dubos</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah</i>		13e. STREET ADDRESS / ZIP CODE <i>2300 Dulaney Valley Rd., 21204</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>-</i>		17. INFORMANT ADDRESS <i>Dr. Eugene B. Brody, 70 Olmsted Green, 21210</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Senile Dementia</i>							
19a. DATE OF OPERATION <i>July 1, 1983</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Senile Dementia</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1983</i> to <i>Sept 5, 1984</i> , that (I) (we) lost saw the deceased alive on <i>Aug. 8, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Kendall Faulkner MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/5/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kendall Faulkner</i>		22e. ADDRESS <i>Stella Maris Hospice</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>9/6/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Catonsville Balto. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>J. E. Lowell Lemmon</i> ADDRESS <i>10 W. Padonia Rd.</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 17 1984</i>		25b. REGISTRAR'S SIGNATURE <i>W. Anderson-Randall</i>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

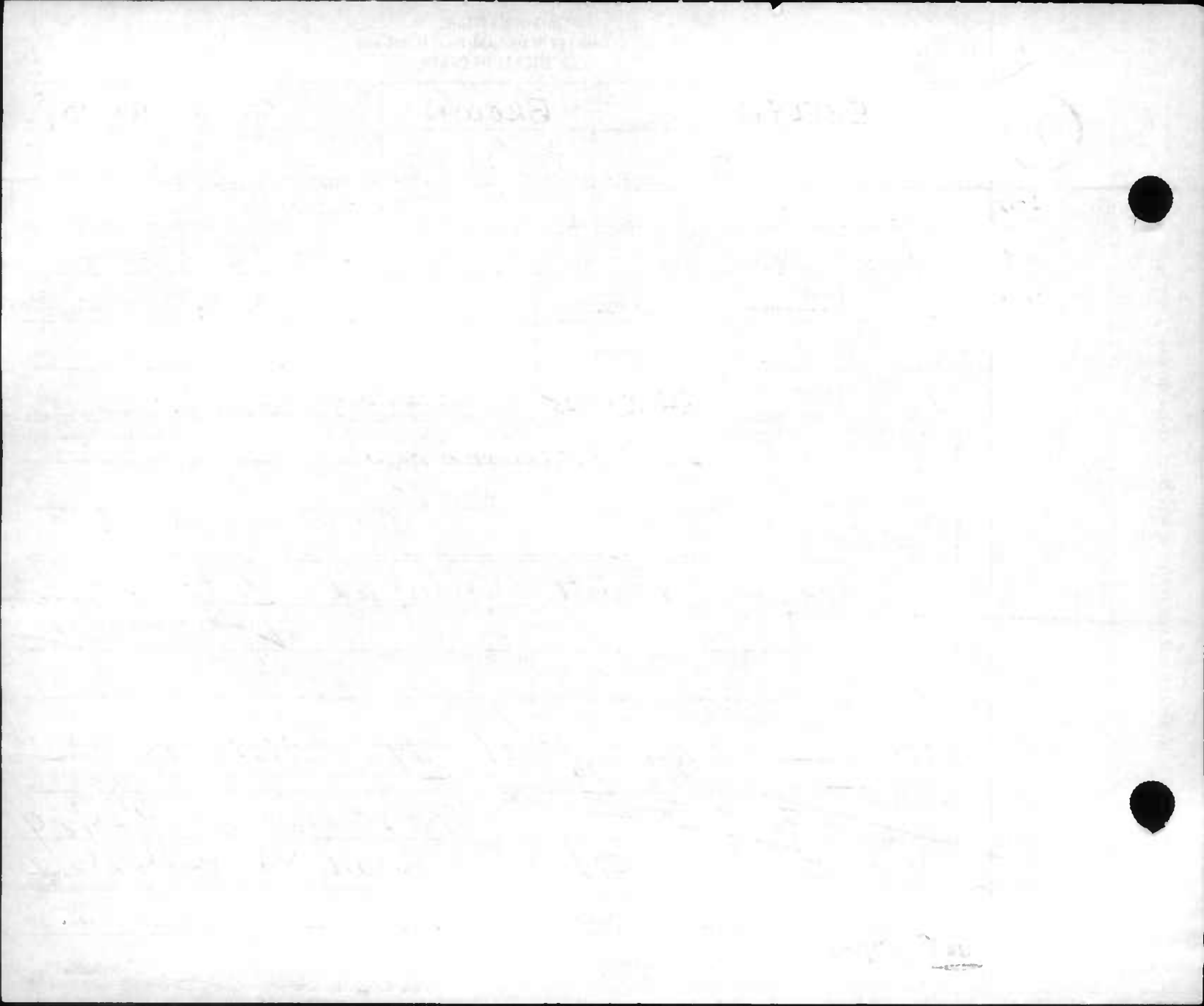
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EVELYN Mae BROWN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT 22 1984</b>		2b. HOUR 10 <sup>10</sup> P.M.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 30 1903</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>County</b>						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley View Nursing Home</b>		12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) <b>Md. Casualty</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Personnel</b>		13a. STREET ADDRESS <b>116 W. University Pkw.</b>				
13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William W. Brown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Daisy B. Powell</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-10-3125</b>		17. INFORMANT ADDRESS <b>Jean Bardelman 1509 Upshire Rd. 21218</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCUP</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>§</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Osteoporosis with collapsed Vertebrae</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/21/84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>9/22/84</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Howard Md.</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>9/21/84</b> to <b>9/22/84</b> , that (I) (we) last saw the deceased alive on <b>9/21/84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Nguyen</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/24/84</b>		
22d. PHYSICIAN'S NAME (LAST, FIRST) <b>VUONG NGUYEN</b>		22e. ADDRESS <b>6331 Belair Rd Balto 21206</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-25-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Howard Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Briggs-Henss 3631 Falls Rd 21211</b>				
25a. DATE REC'D. BY REGISTRAR <b>SEP 24 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

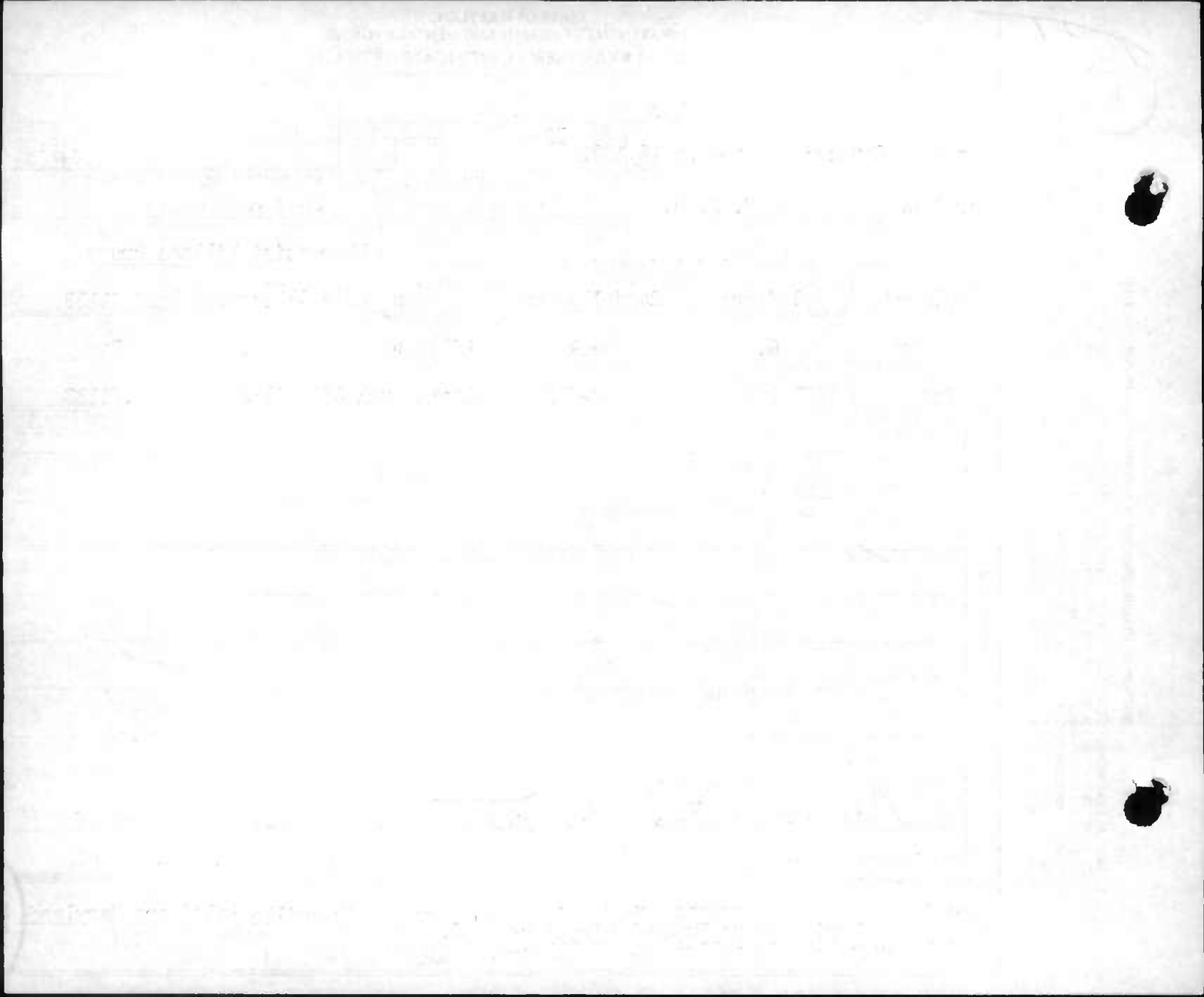
BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT Lee BUCK</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>9 4 19 84</b>		2b. HOUR M <b>9:50 a.m.</b>			
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 18, 1932</b>		6. AGE (IN YRS.) <b>52</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 4 19 84</b>		2d. HOUR M <b>9:50 a.m.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Randallstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. Co. Gen. Hosp.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pharmacist Village Drugs</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8614 Allenswood Road 21133</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony B. Buck</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian M. Daw</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes 1953 1955</b>				16b. SOCIAL SECURITY NO. <b>215-28-5293</b>		17. INFORMANT ADDRESS <b>Johanna Buck 8614 Allenswood Rd. 21133</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER				DATE SIGNED <b>9-4-84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>09/07/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, INC. 8728 Liberty Road Randallstown, MD 21133-4784</b>										25a. DATE REC'D. BY REGISTRAR <b>SEP 6 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANNIE V BUCKLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 2 84</b>		2b. HOUR <b>12<sup>50</sup> AM</b>	
3 SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06- 24 95</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>89</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>COUNTY, BALTIMORE MD</b>
10. CITY OR TOWN OF DEATH <b>DUNDALK, BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN NURSING CENTER-HERITAGE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ASST. BUYER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>--- --- GATTON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JANE --- BRADBURN</b>		13e. STREET ADDRESS <b>8017 Old Philadelphia Road 21237</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-10-8067</b>		17 INFORMANT ADDRESS <b>EMERSON W. BUCKLER 8017 d OLD PHILA. RD.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular Accident. Right</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>3 months</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>congestive Heart failure. 3 years.</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7/25/84 19 84 9/2/ 19 84</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/31/84</b> to <b>9/2/84</b> , that (I) (we) lost saw the deceased alive on <b>8/31/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Harjit Singh</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/3/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARJIT SINGH M.D.</b>		22e. ADDRESS <b>#8. 16 W AVE., BALTO, Md. - 21225</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>09/04/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAUL'S CHURCH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LUSBY CALVERT MD</b>
24. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>1211 Chesaco Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

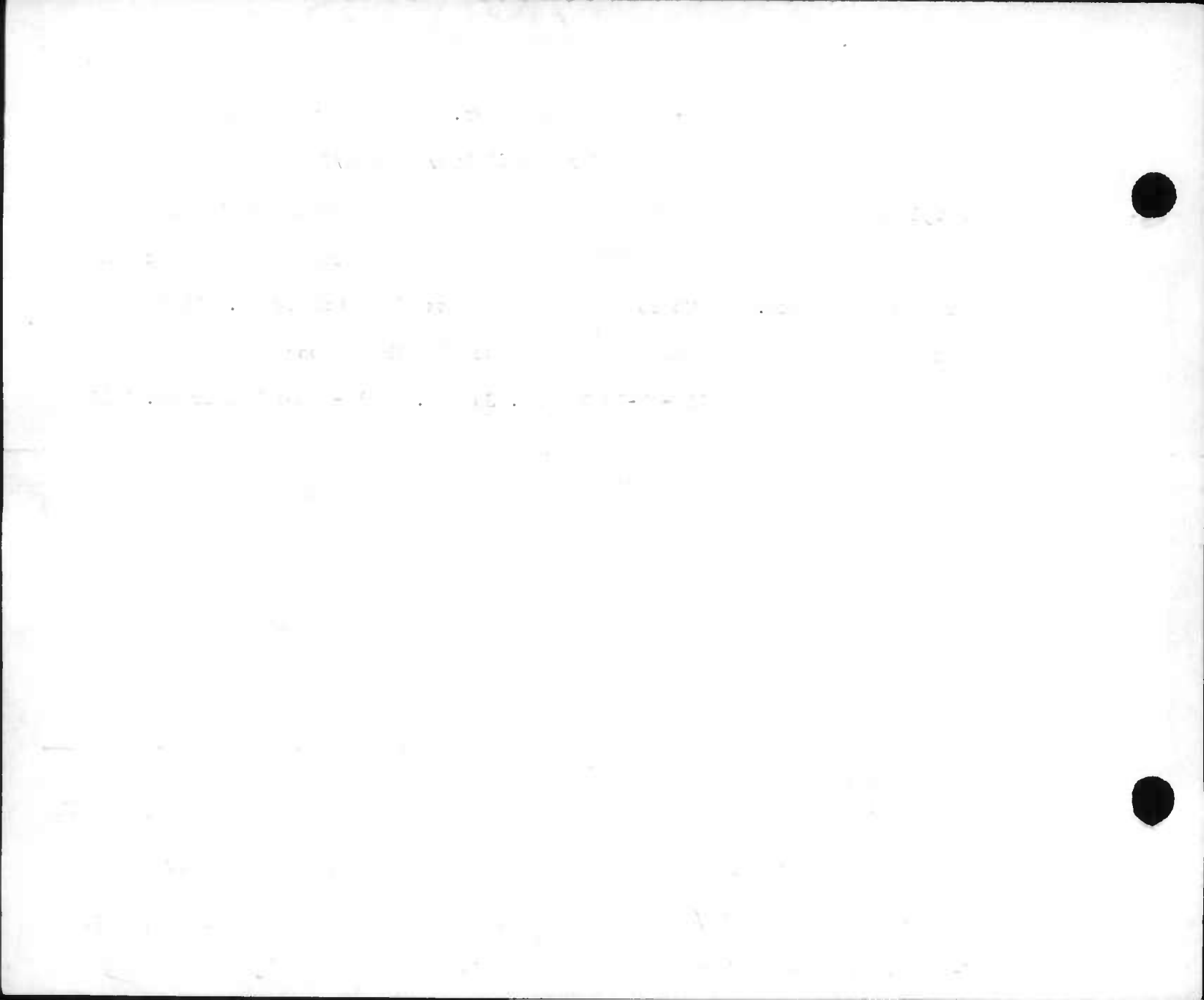
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HOWARD I. BULL Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 26, 1984</b>		2b. HOUR M <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 8 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Towson</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Contractors</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Irving Bull</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stella May Hood</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		
		16b. SOCIAL SECURITY NO. <b>215-03-1903</b>		17. INFORMANT ADDRESS <b>Mr. John F. Bull - 1807 Miller Rd. 21030</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PROBABLE SEPTICEMIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 HRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9-26 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (the deceased) attended the deceased from <b>5-22 19 79</b> to <b>9-26 19 84</b> , that (I) (we) saw the deceased alive on <b>9-26 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Henri T. Voorstad M.D.</b>				22c. DATE SIGNED <b>9-27-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henri T. Voorstad, M.D.</b>				22e. ADDRESS <b>7600 Osler Drive Towson, Md. 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/29/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn, Balto., Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 27 1984</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Helen Dorothy Bullock</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 7, 1984</b>			2b. HOUR M <b>12</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/22/14</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Essex 21221</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>325 Ida Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>325 Ida Ave. 21221</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Drozd</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Michaleana Gudanowski</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>--</b>		17. INFORMANT ADDRESS <b>Edward Bullock (husband) (same)</b>					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS</b>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 14, 1984</b> to <b>SEPT. 7, 1984</b> that (I) (we) lost saw the deceased alive on <b>AUG. 14, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Fausto Q. Aguirre Jr. MD</b>						22c. DATE SIGNED <b>9-7-84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FAUSTO Q. AGUIRRE JR.</b>						22e. ADDRESS <b>8713 HARFORD RD BALTO.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/20/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cem.</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Baltimore County, Maryland</b>			
24. FUNERAL DIRECTOR <b>Eryndzinski Funeral Home PA 1407 Old Eastern Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>			25b. REGISTRAR'S SIGNATURE <b>John Davidson-Bond</b>	

BP

1, 7, 10, 13, 16, 19, 22, 25, 28, 31, 34, 37, 40, 43, 46, 49, 52, 55, 58, 61, 64, 67, 70, 73, 76, 79, 82, 85, 88, 91, 94, 97, 100, 103, 106, 109, 112, 115, 118, 121, 124, 127, 130, 133, 136, 139, 142, 145, 148, 151, 154, 157, 160, 163, 166, 169, 172, 175, 178, 181, 184, 187, 190, 193, 196, 199, 202, 205, 208, 211, 214, 217, 220, 223, 226, 229, 232, 235, 238, 241, 244, 247, 250, 253, 256, 259, 262, 265, 268, 271, 274, 277, 280, 283, 286, 289, 292, 295, 298, 301, 304, 307, 310, 313, 316, 319, 322, 325, 328, 331, 334, 337, 340, 343, 346, 349, 352, 355, 358, 361, 364, 367, 370, 373, 376, 379, 382, 385, 388, 391, 394, 397, 400, 403, 406, 409, 412, 415, 418, 421, 424, 427, 430, 433, 436, 439, 442, 445, 448, 451, 454, 457, 460, 463, 466, 469, 472, 475, 478, 481, 484, 487, 490, 493, 496, 499, 502, 505, 508, 511, 514, 517, 520, 523, 526, 529, 532, 535, 538, 541, 544, 547, 550, 553, 556, 559, 562, 565, 568, 571, 574, 577, 580, 583, 586, 589, 592, 595, 598, 601, 604, 607, 610, 613, 616, 619, 622, 625, 628, 631, 634, 637, 640, 643, 646, 649, 652, 655, 658, 661, 664, 667, 670, 673, 676, 679, 682, 685, 688, 691, 694, 697, 700, 703, 706, 709, 712, 715, 718, 721, 724, 727, 730, 733, 736, 739, 742, 745, 748, 751, 754, 757, 760, 763, 766, 769, 772, 775, 778, 781, 784, 787, 790, 793, 796, 799, 802, 805, 808, 811, 814, 817, 820, 823, 826, 829, 832, 835, 838, 841, 844, 847, 850, 853, 856, 859, 862, 865, 868, 871, 874, 877, 880, 883, 886, 889, 892, 895, 898, 901, 904, 907, 910, 913, 916, 919, 922, 925, 928, 931, 934, 937, 940, 943, 946, 949, 952, 955, 958, 961, 964, 967, 970, 973, 976, 979, 982, 985, 988, 991, 994, 997, 1000.

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and pages 3 and 4 must be completed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leslie M. Burgemeister</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 29, 1984</b>		2b. HOUR <b>9:49 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 20, 1905</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>79</b>		
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Multi-Medical Center</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>						
12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>305 Quaker Ridge Road 21093</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>James H. Robb</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Ecoff</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>389-07-1310D</b>		17. INFORMANT ADDRESS <b>Mrs. Jean M. Clayton Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR Accident (multiple)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertensive Cardiovascular Disease</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>4-24</b> 19 <b>70</b> to <b>9-29</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>9-28</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Sidney J. Venable M.D.</b>		DEGREE		22c. DATE SIGNED <b>10-1-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Sidney J. Venable</b>		22e. ADDRESS <b>7215 York Road Baltimore, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 2, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>						
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>				
25b. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>						



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 2 3 5 2 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELSIE RHINEHART BURTON</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>2</b> YEAR <b>84</b>		2b. HOUR <b>7:35AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>FEB.</b> DAY <b>4</b> YEAR <b>1900</b>		6. AGE [IN YEARS (LAST BIRTHDAY)] <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N CHARLES STREET</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT Home</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>CARNEY</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>10005 HARFORD ROAD</b>	
14. FATHER'S NAME FIRST <b>EUGENE C.</b> MIDDLE <b></b> LAST <b>REINHARD</b>		15. MOTHER'S MAIDEN NAME FIRST <b>EMILY</b> MIDDLE <b></b> LAST <b>AKSHURST</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-031688A</b>		17. INFORMANT <b>FAMILY RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC HYPOXIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>INTRACEREBRAL EXENT</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/1</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>9/1</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>9/2</b> <b>84</b> <b>9/2</b> <b>84</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/2</b> <b>84</b> to <b>9/2</b> <b>84</b> that (I) (we) last saw the deceased alive on <b>9/2</b> <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. J. Lustbader, MD</b>		DEGREE		22c. DATE SIGNED <b>9/2/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. J. LUSTBADER, M.D.</b>		22e. ADDRESS <b>6701 N. CHARLES STREET / GBMC</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>9-5-1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>PARKVILLE BALTO. MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPLOF MEMORIES</b>		ADDRESS <b>8800 HARFORD RD.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 5 1984</b>	
		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to certify.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

MASS: 7:35AM

ELsie RHINEHART BURTIN

84

REMALE

BALTIMORE COUNTY

GBMC 6701 N CHARLES STREET

CATHOLIC MARY ANN EST

CHRONIC HYPOXIA

INTRACEREBRAL EXAM

GBMC 6701 N. CHARLES STREET

DR. J. LUSTBADER, M.D.



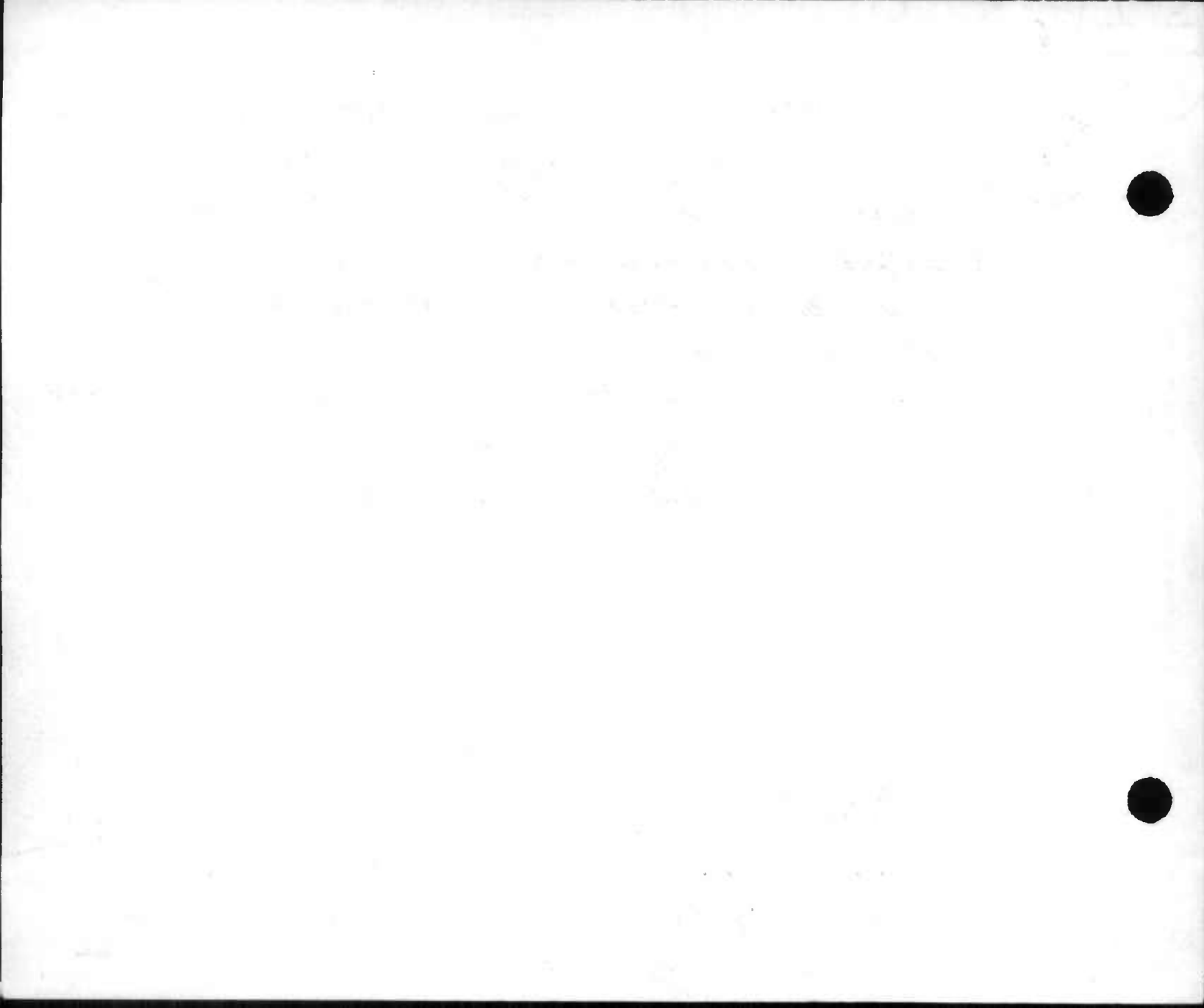
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William Henry BUSCHMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 29, 1984</b>			2b. HOUR <b>7:36 P.M.</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6/15/11</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>73</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>M.D.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>			
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQ.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>M.D.</b>			13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK BUSCHMAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH SCHOEBERLEIN</b>			13e. STREET ADDRESS / ZIP CODE <b>432 VIRGINIA AVE 21221</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNK</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212 05 8412</b>		17. INFORMANT ADDRESS <b>MARGARET BUSCHMAN ABOVE</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest, Probable Pulmonary Embolus</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>September 29, 1984</b> to <b>September 29, 1984</b> , that (I)(we) last saw the deceased alive on <b>September 29, 1984</b> , and that in (X)(y) (aur) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J.M. Niehoff</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9/29/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.M. Niehoff, M.D.</b>						22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10/2/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. M.D.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>J.G. CONNELL 300 MACE</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 3 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

BP



FOR  
1 - STATE  
REGISTRAR **MADELEINE JASPER BUTERBAUGH**

1. DECEASED NAME (TYPE OR PRINT) <b>MADELEINE J. BUTERBAUGH</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9 11 84</b>		2b. HOUR <b>11:57 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 29, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY</b> MD	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1031 View Street 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick W. Jasper</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hettie Mc Cord</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>068-09-7634</b>	17. INFORMANT <b>L. Byron Buterbaugh</b>		ADDRESS <b>1031 View Street Hagerstown, Md. 21740</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Extensive Atelectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Status post coronary artery bypass surgery</b> <b>SIC Coronary Bypass Surgery</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ASLD (Arteriosclerotic cardiovascular disease)</b>					
19a. DATE OF OPERATION <b>7/84</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary Artery Disease</b>	20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/11</b> , 19 <b>84</b> , to <b>9/11</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>7/11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE <b>Jeffrey J. Quarter</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey Quarter, M.D.</b>		22e. ADDRESS <b>2924 N. Charles St</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9-14-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Beaver Creek Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beaver Creek, Washington, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Gilda Davidson-Rendall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified in writing.

BP

WASHINGTON, D. C.

MADEIRA J. BUTTERFIELD

23

Sept. 29, 1910

White

Female

X

U.S.A.

1000

Barry County

Honolulu

Tolson, J. Edgar Hoover

1910

101 View Street

X

Washington

Washington

Washington

10 Corn

101 View Street

101 View Street

101 View Street

101 View Street

101 View Street

101 View Street

101 View Street

10

1/2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 2 4

1. DECEASED NAME (TYPE OR PRINT) <b>Donald E Callahan</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 8 1984</b>			2b. HOUR <b>1:30 PM</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 21 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) (STATE OR FOREIGN) <b>Baltimore County</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Berwyns town</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Reisterstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>553 Gwynnwest Rd. 21136</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Callahan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Chaney</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>yes WWII</b>		16b. SOCIAL SECURITY NO. <b>212-22-4266</b>		17. INFORMANT <b>Mary Callahan</b>	
16a. ADDRESS <b>553 Gwynnwest, Reist.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barrocardogenic Coarctation - aortic dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-9</b> , 19 <b>84</b> , to <b>9-8</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9-8</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William J. Chircus M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9-8-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William J. Chircus M.D.</b>				22e. ADDRESS <b>32-k Stockmill Rd 21208</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept 11/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Owings Mills Balto Md</b>			
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home</b>				ADDRESS <b>Reist. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Gordon-Pendell</b>	

BP



John

Will

William

1870-1880

William

1870-1880

John

1870-1880

1870-1880

1870-1880

1870-1880

1870-1880

1870-1880

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1870-1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Aaron</u> <u>Morton</u> <u>Caplan</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>9</u> <u>30</u> <u>1984</u>		2b. HOUR <u>1:30 AM</u>
3. SEX <u>male</u>	4. RACE <u>white</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>1</u> <u>18</u> <u>1924</u>		6. AGE (IN YEARS (LAST BIRTHDAY)) <u>60</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S. B.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore county</u> MD.	
10. CITY OR TOWN OF DEATH <u>Randallstown</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore county General Hosp</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>PRINTER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>
13a. STATE <u>Maryland</u>	13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Randallstown</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>8612 WOODSPRING RD. 21133</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>BENJAMIN</u> <u>CAPLAN</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ETHEL</u> <u>Levin</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>		16b. SOCIAL SECURITY NO. <u>WWII-ARMY 217-18-2822</u>		17. INFORMANT ADDRESS <u>MRS. MIRIAM CAPLAN 8612 WOODSPRING RD. 21133</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Left Ventricular Failure</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Recurrent - Multiple M.I.'s, Old L + C.U.A.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-18</u> , 19 <u>84</u> , to <u>9-30</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>9-30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Allen J. Church M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>9-30-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Allen J. Church M.D.</u>		22e. ADDRESS <u>32-k-Stockmill RD. Pikesville 21208</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>10-1-84</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETH EL MEMORIAL PARK</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>RANDALLSTOWN BALTIMORE MARYLAND</u>
24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 3 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Jane Warden-Randall</u>	
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215					

BP

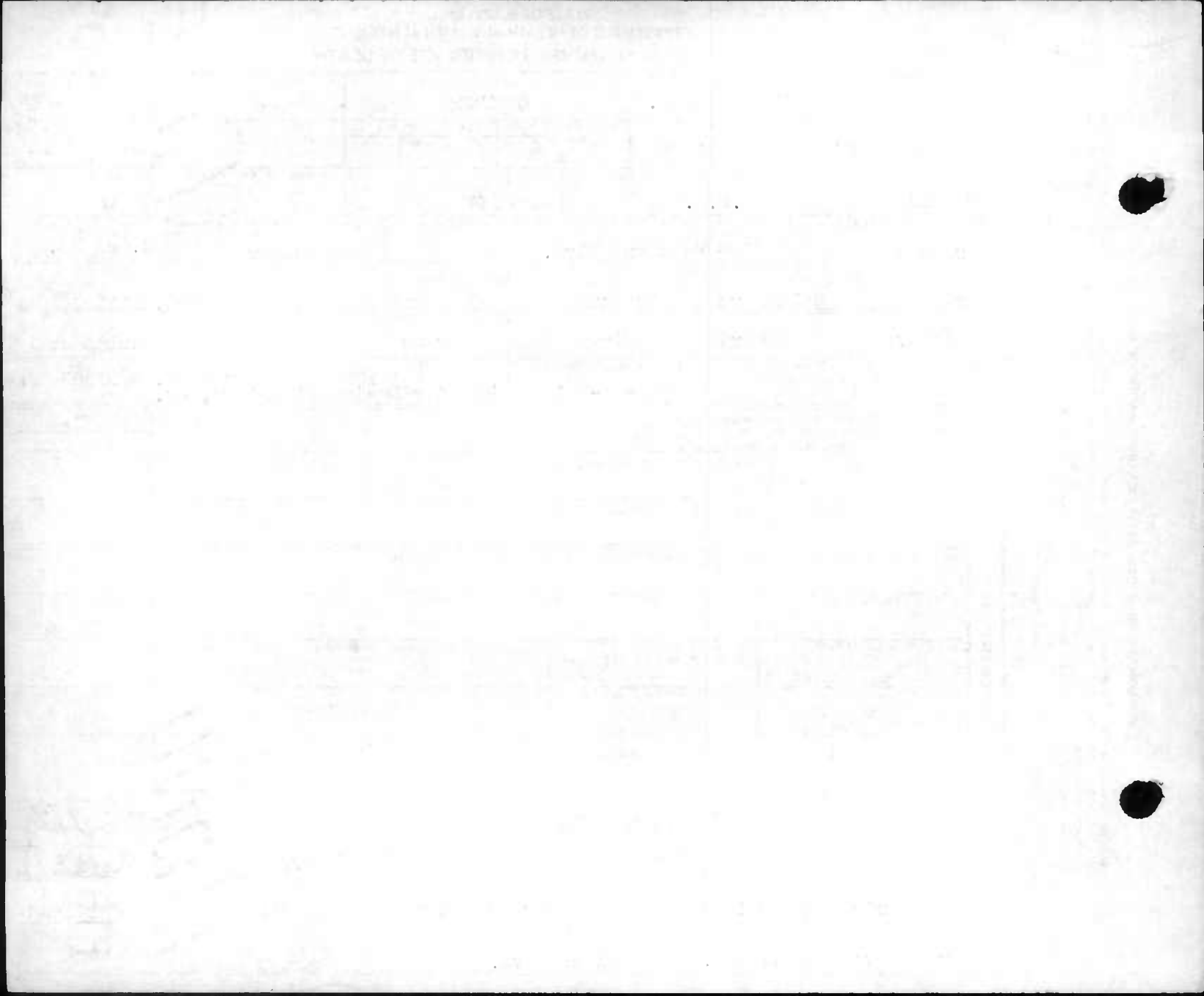




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PMA 3. RETAIN PAGE FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23520	
1. DECEASED NAME (TYPE OR PRINT) <b>GARNET R. CARTER</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>9 28 1984</b>		2b. HOUR <b>9:30 PM</b>			
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>5</b> DAY <b>13</b> YEAR <b>07</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>77</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD <b>9 28 1984</b>		2d. HOUR <b>9:30 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>Arbutus</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5108 Westland Blvd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>St. of Md.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5108 Westland Blvd. 21227</b>			
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>Howard</b> LAST <b>Ring</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Irene</b> MIDDLE <b></b> LAST <b>Denlinger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-07-8842</b>		17. INFORMANT ADDRESS <b>13312 Shadberry La. 33567</b> <b>William Louis Reimsnyder, Jr.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A.S.C. V.D.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>90 HRS</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET <b></b>		CITY OR TOWN <b></b>		COUNTY <b></b> STATE <b></b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. P. Williamson</b>		TITLE (SPECIFY) <b>M.D. Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>9/28/84</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>E. P. Williamson</b>		ADDRESS <b>5650 BALTONA T. L. Pk. 21227</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/2/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>				ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Pendleton</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

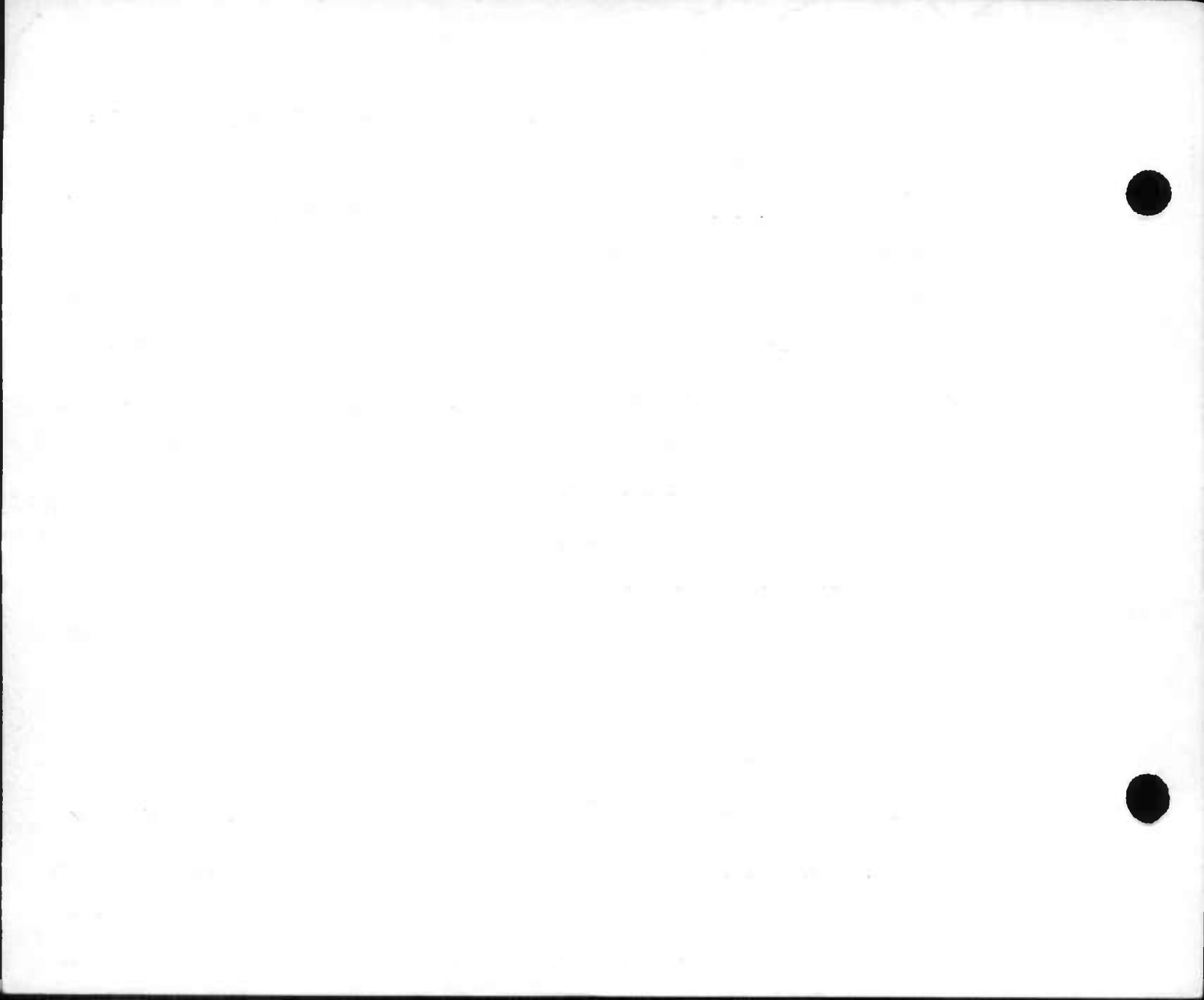
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 4/83  
(VRA 15, 4)

1 - FOR STATE REGISTRAR				XC 15 911 530				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23521			
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE WASHINGTON CARTHON</b>								2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 10, 1984</b>				2b. HOUR <b>11:20 P M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 8, 1894</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>90 YRS</b>		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TENNESSEE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>							
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRINTER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>SUN PAPERS</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>TOWSON</b>		13e. STREET ADDRESS / ZIP CODE <b>801 SHAW COURT 21204</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE EDWARD CARTHON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DORA BELLE JONES</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI</b>		17. INFORMANT ADDRESS <b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b>												<b>DAYS</b>			
DUE TO, OR AS A CONSEQUENCE OF															
(b) <b>PERINEPHRIC ABSCESS</b>												<b>DAYS</b>			
DUE TO, OR AS A CONSEQUENCE OF															
(c) <b>PYELONEPHRITIS AND NEPHROUTHIASIS</b>												<b>YEARS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>S/P RIGHT BELOW KNEE AMPUTATION</b>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 19 19 84</b> to <b>SEPTEMBER 10 19 84</b> that (I) (we) last saw the deceased alive on <b>SEPTEMBER 10 19 84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (did not) view the body after death.)															
22b. SIGNATURE <i>Peter V. Juvan</i> DEGREE <b>M.D.</b>								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/11/84</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER V. JUVAN, M.D.</b>								22e. ADDRESS <b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>9-13-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>								25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

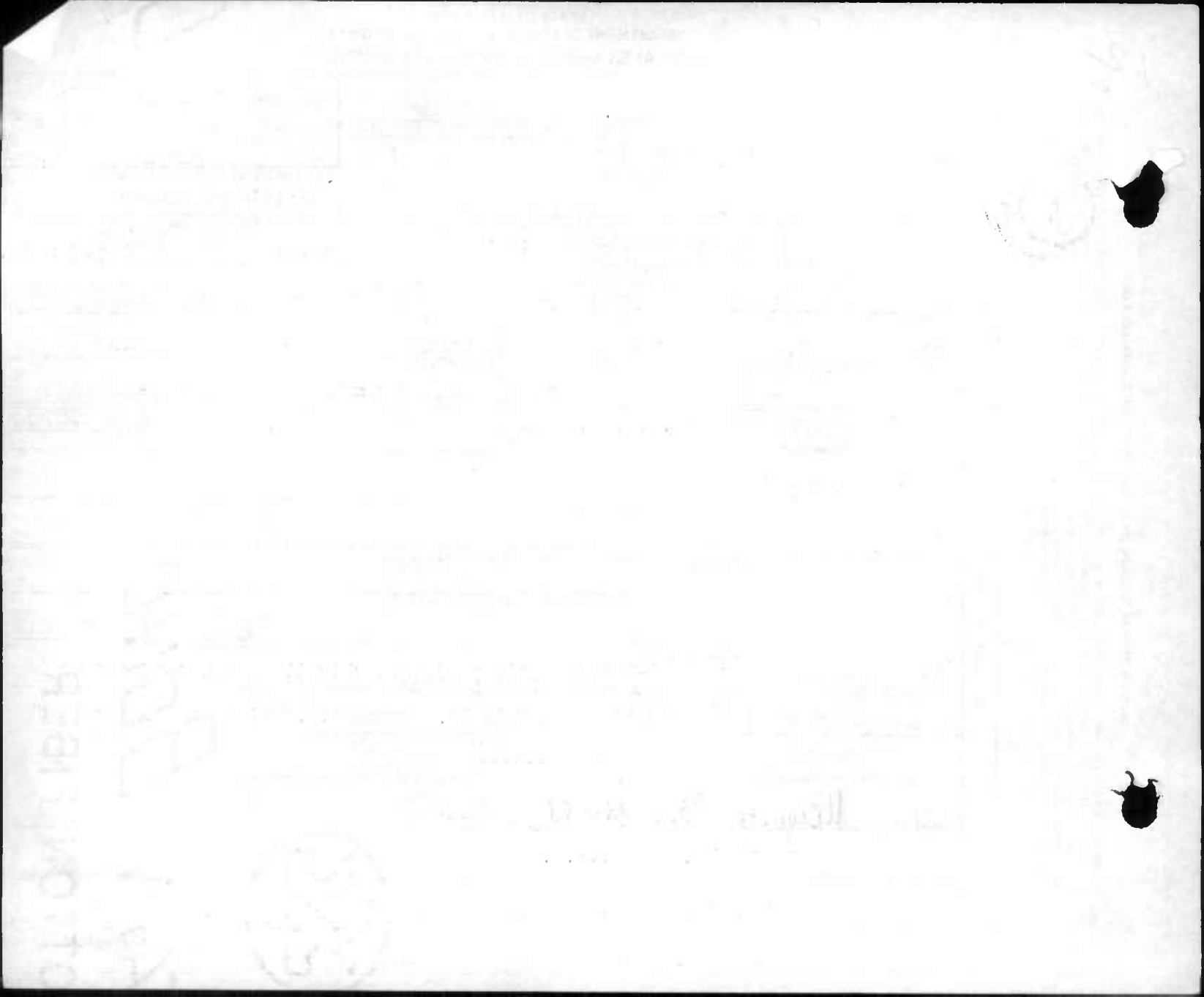
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23528

1- STATE REGISTRAR						2a. DATE KNOWN OF DEATH						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT M. CAVE						DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9-27-84 19						2b. HOUR M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1/15/07		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-27-84 19		2d. HOUR 2:45a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager				12b. KIND OF BUSINESS OR INDUSTRY T. One Realty Co.	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7 Farwell Ct, 21236			
14. FATHER'S NAME FIRST MIDDLE LAST Harry H. Cave						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura V. Kinney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Helen Tumminello, dghtr, same add.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Multiple injuries 8160 IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 9:58 AM MONTH DAY YEAR 9-27-84 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto which left the road and went into a ditch							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Vale Dr. & Yvonne Ave. White Marsh, Maryland							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Margarita A. Korel, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER						DATE SIGNED 9-27-84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korel, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/29/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS SCHIMUNEK FUNERAL HOME, 3331 Brehms La,						25a. DATE REC'D. BY REGISTRAR 28 SEP 28 1984				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

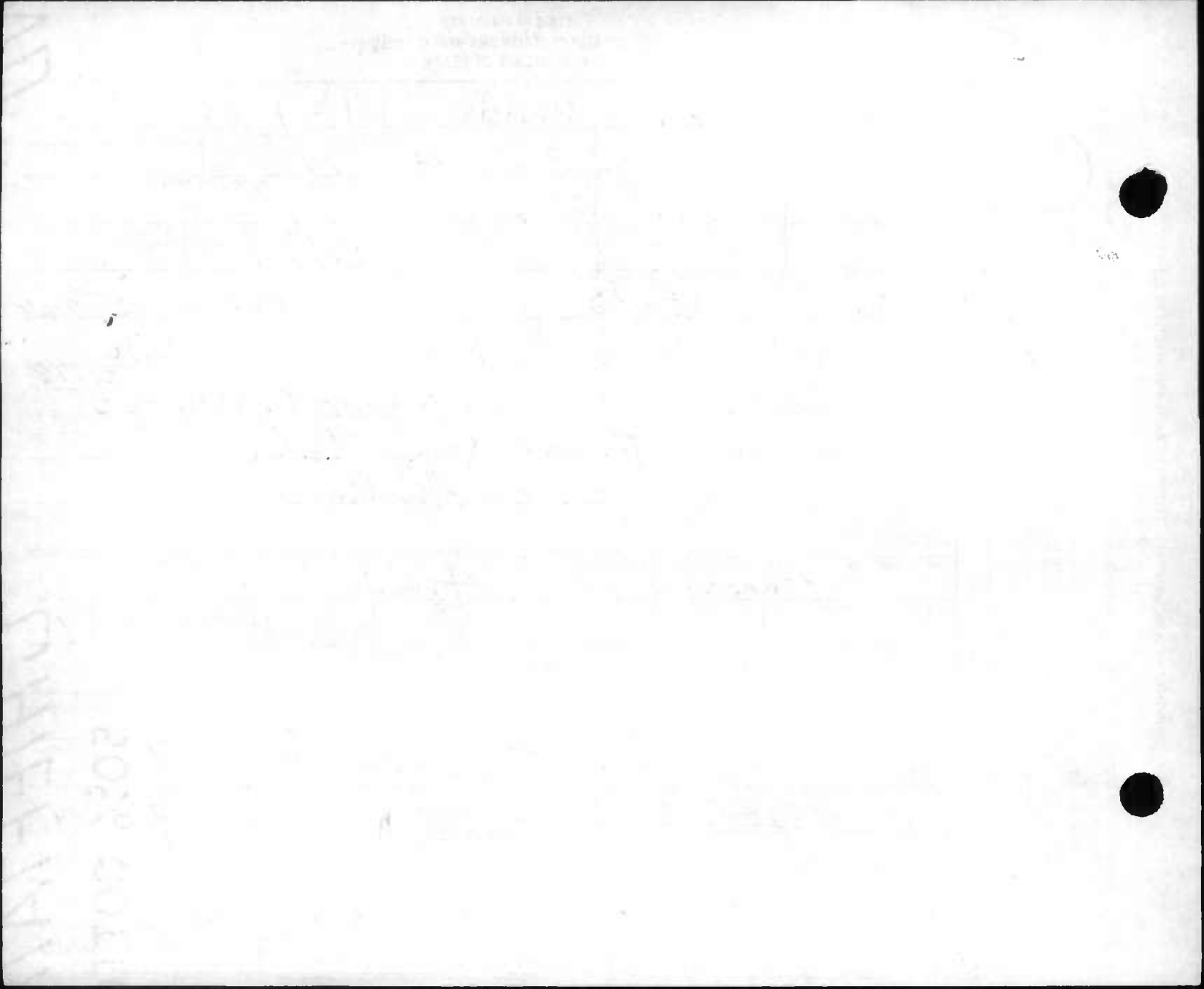
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George A. Childs</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-4-84</b>		2b. HOUR <b>11A</b> M
1. SEX <b>male</b>	3. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-26-93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley View Nsgl Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b> COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3104 BARCLAY ST 21218</b>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Childs</b> LAST <b>Childs</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ELLA</b> MIDDLE <b>Hopkins</b> LAST <b>Hopkins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) <b>yes</b> (IF YES, GIVE WAR OR DATES) <b>WWI</b>		16b. SOCIAL SECURITY NO. <b>216-09-1787A</b>		17. INFORMANT ADDRESS <b>Miss Helen Norman 3117 Barclay St 21218</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Anemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Anemia</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Anemia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/23/84</b> to <b>9/4/84</b> that (I) (we) last saw the deceased alive on <b>8/23/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Vuong Vu Nguyen</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/5/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VUONG VU NGUYEN</b>		22e. ADDRESS <b>6331 Bclair Rd 21206</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-7-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO NAT CEM</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>		25a. DATE RECD. BY REGISTRAR <b>SEP 11 1984</b>			
24. FUNERAL DIRECTOR NAME <b>JOSEPH L. RUSE</b> ADDRESS <b>2222 W. NORTH AVE</b>		25b. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 3 5 3 0

1 - FOR  
STATE  
REGISTRAR

REG. NO.

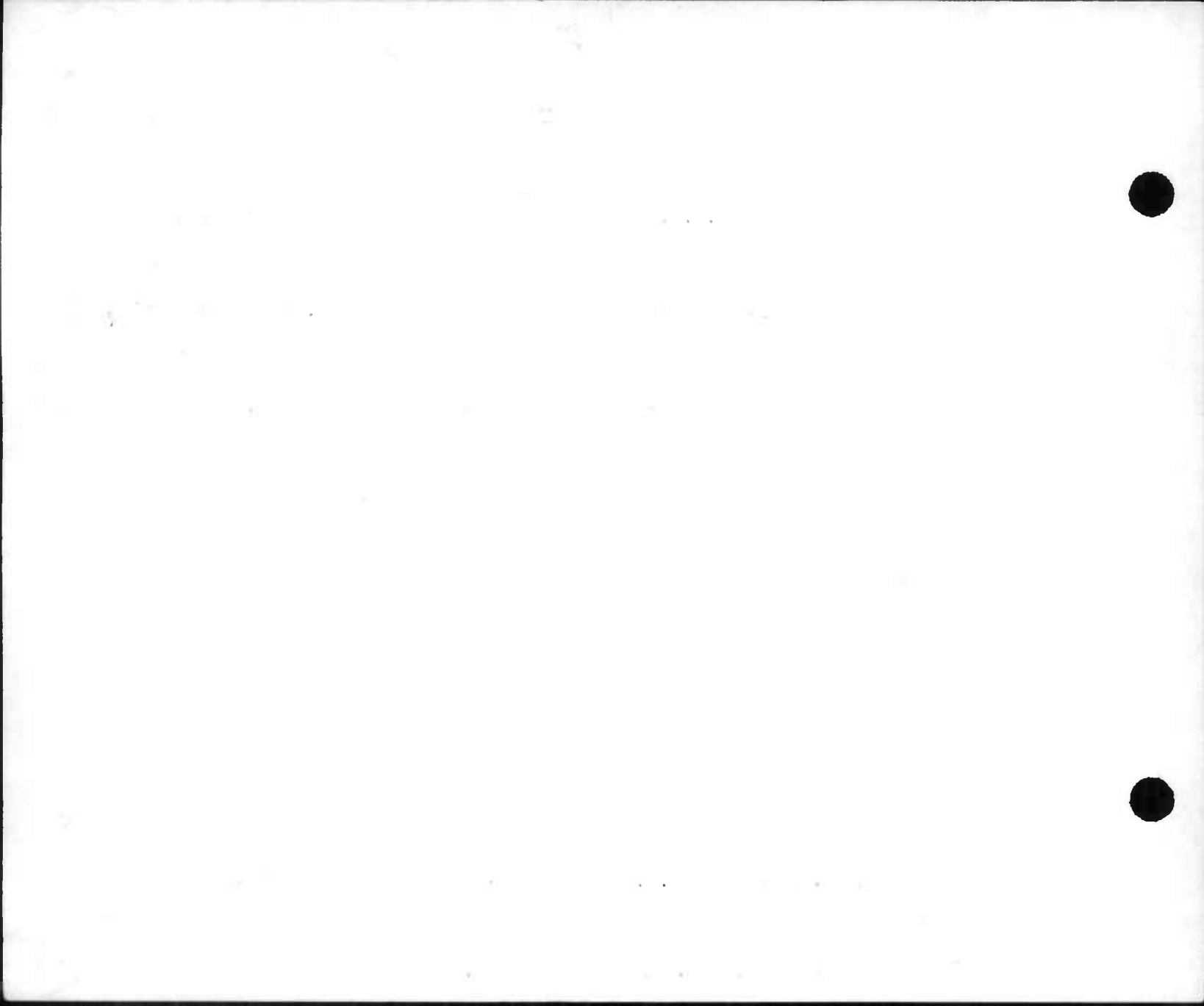
1. DECEASED NAME (TYPE OR PRINT) <b>PAUL CHYLINSKI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 12 84</b>			2b. HOUR <b>2:18 PM</b>		
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>02 24 08</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>			MD	
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN NURSING CENTER</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSTALLER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STORM DOOR &amp; WINDOW</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>CATONSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>119 S. PROSPECT AVENUE, 21228</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEON CHYLINSKI</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>577-14-7424</b>		17. INFORMANT ADDRESS <b>JADWIGA CHYLINSKI 119 S. PROSPECT AVENUE 21228</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Probable rupture of aortic aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Anterovascular disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Anterovascular cardiovascular disease</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>9-12</b> 19 <b>84</b> to <b>9-12</b> 19 <b>84</b> that (we) last saw the deceased alive on <b>9-12</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Laurence R. Gallagher, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-12-84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAURENCE R. GALLAGHER, M.D.</b>				22e. ADDRESS <b>ST. AGNES MEDICAL CENTER, 21229</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>09-15-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>				ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John A. Anderson</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR **XC 0376508**

5-41

23531

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**SAMUEL NMN CIGNORE**

2a. DATE OF DEATH MONTH DAY YEAR  
**SEPTEMBER 28, 1984**

2b. HOUR <sup>P</sup>  
**6:00**

3. SEX  
**MALE**

4. RACE  
**WHITE**

5. DATE OF BIRTH MONTH DAY YEAR  
**SEPTEMBER 2, 1896**

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.  
**88**

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**ITALY**

7b. CITIZEN OF WHAT COUNTRY?  
**UNITED STATES OF AMERICA**

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**BALTIMORE COUNTY MD**

10. CITY OR TOWN OF DEATH  
**FORT HOWARD**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**VETERANS ADMINISTRATION MEDICAL CENTER**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Urbom**

12b. KIND OF BUSINESS OR INDUSTRY  
**Horse Farm**

13a. STATE  
**MARYLAND**

13b. COUNTY  
**BALTIMORE**

13c. CITY OR TOWN  
**Essex 21221**

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE  
**237 LANGLEY ROAD 21221**

14. FATHER'S NAME FIRST MIDDLE LAST  
**Unknown**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Unknown**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
**YES**

16b. SOCIAL SECURITY NO.  
**212 14 2016**

17. INFORMANT ADDRESS  
**Mary Cignore, Wife Same**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **WIDESPREAD METASTATIC DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **CANCER TRANSVERSE COLON**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**SEVERE CACHEXIA, UPPER GASTROINTESTINAL BLEEDING, ORGANIC BRAIN SYNDROME, HISTORY ASPIRATION PNEUMONIA**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART II, OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME STREET FACTORY OFFICE FARM ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (X) this hospital attended the deceased from **AUGUST 21** 19 **84** to **SEPTEMBER 28** 19 **84**, that (X) we last saw the deceased alive on **SEPTEMBER 28** 19 **84**, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) we (did not) see the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

**PRADIP KANANI, M.D.****V Kanani MD****SEPTEMBER 28, 1984**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**PRADIP KANANI, M.D.****VA MEDICAL CENTER, FORT HOWARD, MARYLAND**

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

23e. COUNTY

**Burial****10/2/84****Holly Hill Memorial Gardens****Baltimore Co., Md. 21052**

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

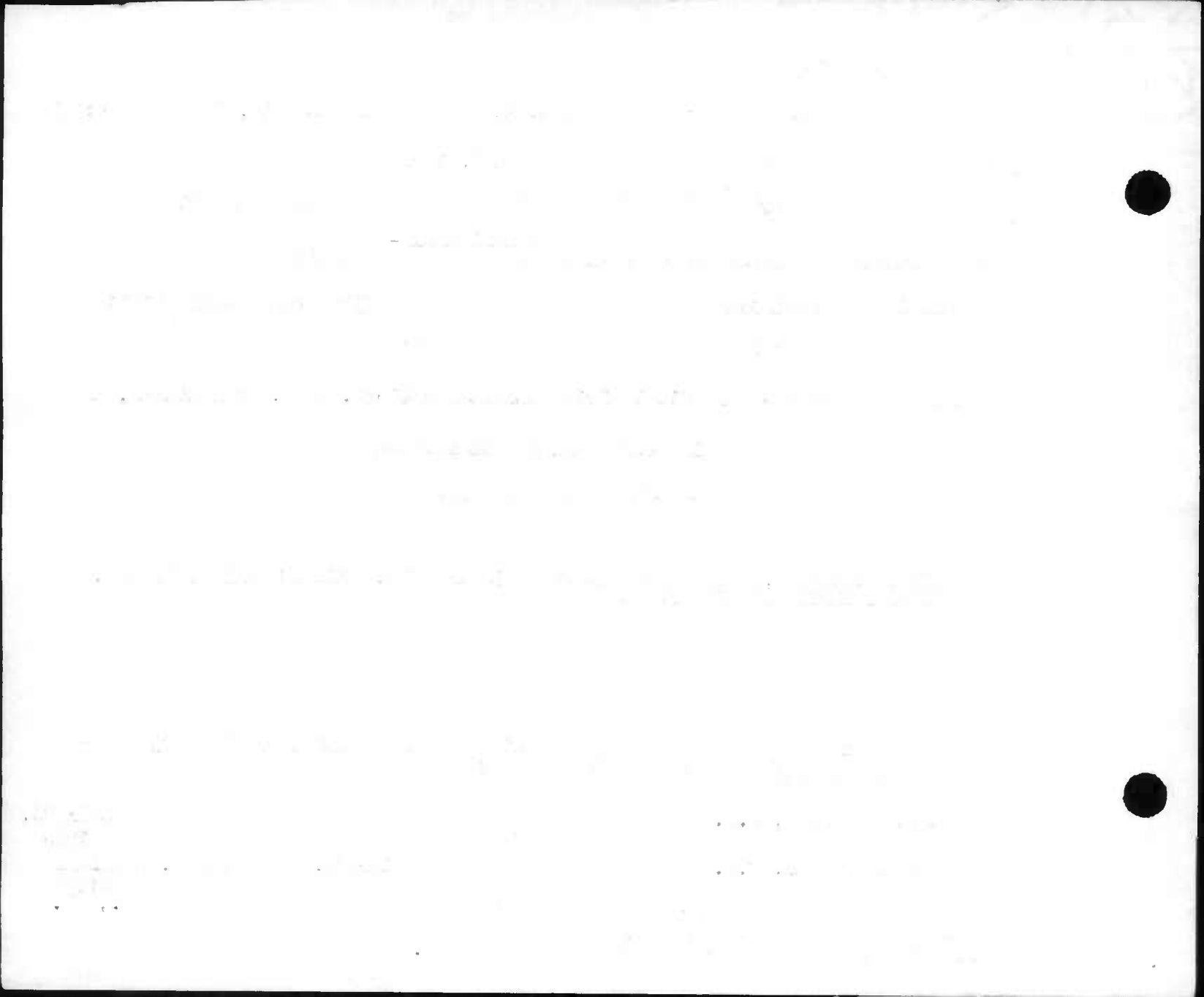
25b. REGISTRAR'S SIGNATURE

**Bruzdzinski Funeral Home PA 1407 Old Eastern Ave****OCT 1 1984****John Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN JOSEPH CLARKE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 21 '84</b>		2b. HOUR <b>12:30 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/1/06</b>		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IRELAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78 YRS.</b>		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Balto.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Clarke</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bridgit McLoughlin</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plasterer</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW II</b>		16b. SOCIAL SECURITY NO. <b>065-05-8624</b>		17. INFORMANT ADDRESS <b>Valdona Clarke, same address</b>		

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **CARDIO-PULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **DIFFUSE CARCINOMATOSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **TRANSITIONAL CELL CANCER KIDNEY**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/21 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/4</b> , 19 <b>84</b> , to <b>9/21</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>9/21</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Lisa Rosenberg MD</i>						22c. DATE SIGNED <b>9/21/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LISA ROSENBERG, M.D.</b>				22e. ADDRESS <b>GBMC - 6701 N. CHARLES ST. 21204</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/25/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR <b>Schmuneck Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 25 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Randall</i>	
3331 Brehms Lane, Balto., Md. 21213							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHNSON CLINTON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT. 25 1984</b>		2b. HOUR <b>5:00 P.M.</b>	
3. SEX <b>M</b>	4. RACE <b>BLK.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 8 1912</b>	6. AGE (IN YEARS (LAST BIRTHDAY)) <b>72</b>	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wadesboro N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Turners Station</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>102 Fleming Dr. 21222</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STEEL WORKER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>	13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>Turners</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>102 Fleming Dr. 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mose Clinton</b>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachel hom AX</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>240-18-7602</b>	17. INFORMANT ADDRESS <b>Virginia Clinton 102 Fleming Dr. 21222</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF THE LUNG &amp; UNK. PRIMARY</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 1, 19 84</b> to <b>SEPT. 25, 19 84</b> , that (I) (we) last saw the deceased alive on <b>SEPT. 25, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Lydia M. Jumamoy, M.D.</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LYDIA M. JUMAMOY</b>				22e. ADDRESS <b>100 N. BRADDOCK ST. BALD. MD. 21231</b>	
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>10-1-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. PK.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1984</b>	
24. FUNERAL DIRECTOR NAME <b>JAS. A. MORTON &amp; SONS</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please reinsert this certificate in the space provided on the permit. Pages 1 and 2 should be filed with the funeral director's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13. 11. 1911

*[Faint, illegible handwritten text covering the majority of the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lester - Conner		2a. DATE OF DEATH MONTH DAY YEAR Sept 28 84		2b. HOUR 6:45 PM	
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 2 16 03		6. AGE (IN YEARS (LAST BIRTHDAY)) 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Co. MD.	
10. CITY OR TOWN OF DEATH LOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PERRING PARK NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. CITY OR TOWN BALTO.	13c. STREET ADDRESS / ZIP CODE 2408 FOSTER AVE 21224		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN CONNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE CAROLINE SCHMIOT		ADDRESS ANNAPOLIS Md. 307 ROGERS HEIGHTS RD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-10-1309		17. INFORMANT JOSEPH GHORIOSO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Obstructive Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Cardiac Arrest</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. Patricia</u>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Patricia MD				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-1-84		23c. NAME OF CEMETERY OR CREMATORY OAKLAWN	
23d. LOCATION CITY OR TOWN BALTO.		COUNTY MD.		STATE	
24. FUNERAL DIRECTOR NAME RAYMOND K. KACOROWSKI		25a. DATE REC'D. BY REGISTRAR OCT 1 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

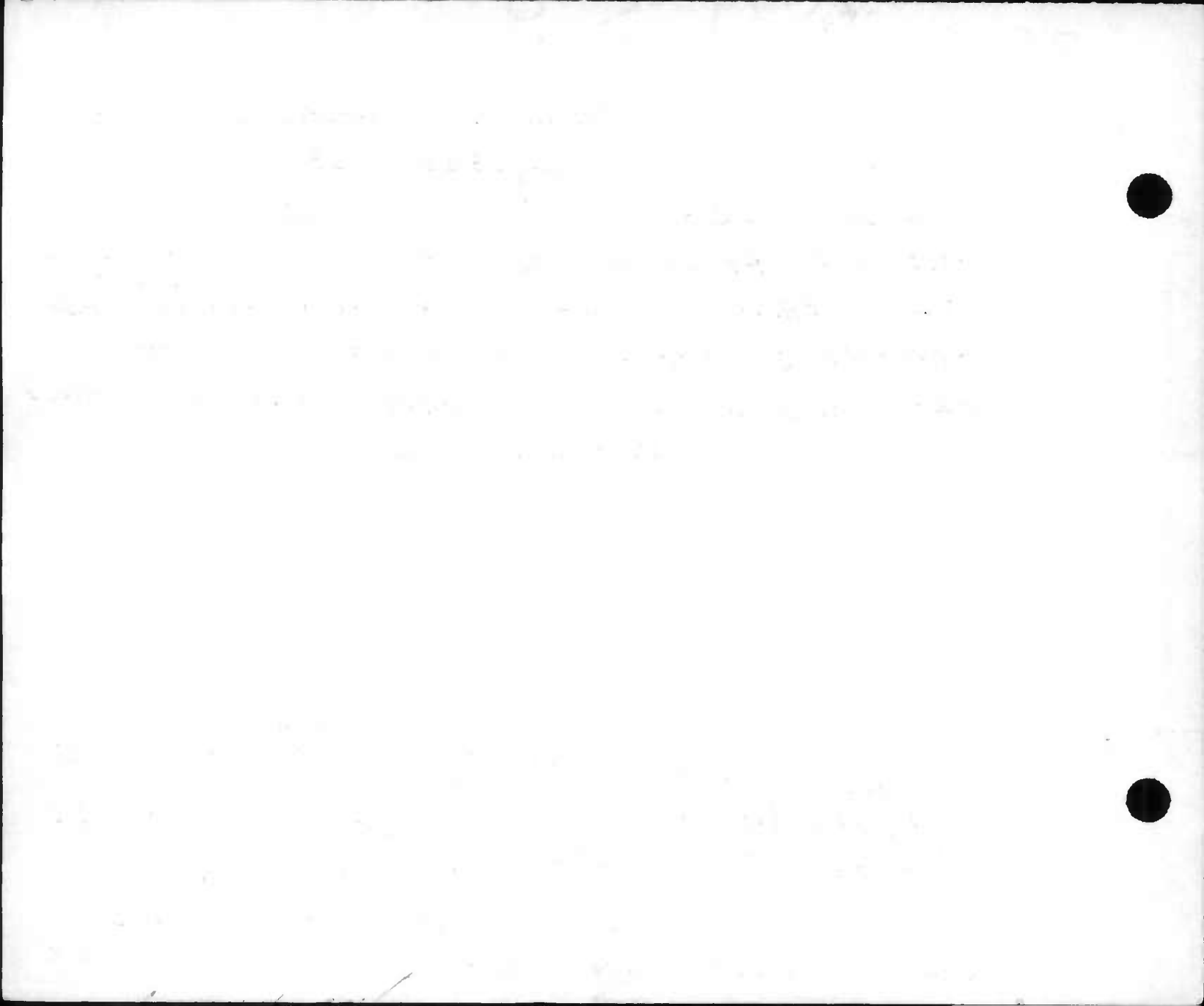
25 Connolly

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

23535

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Raymond C Corkran Sr.			2a. DATE OF DEATH MONTH DAY YEAR September 9, 1984		2b. HOUR 9:39p M	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12/28/25		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY TRUCKING	
13a. STATE MD	13b. COUNTY BALTO	13c. CITY OR TOWN ROSSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4030 CHESTNUT RD 21220		
14. FATHER'S NAME FIRST MIDDLE LAST RAYMOND J. CORKRAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MADELINE UNK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS MARGARET CORKRAN ABOVE		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from September 9, 1984, to September 9, 1984, that (2) we last saw the body on September 9, 1984, and that in (my/our) opinion death occurred on the date and hour and from the causes stated (above/under/elsewhere) (did not) view the body after death.						
22b. SIGNATURE Rafael Perez Luna		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-11-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAFAEL PEREZ LUNA		22e. ADDRESS 9000 Franklin Square Dr. 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/14/84	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME J.G. CONNELLY			ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR SEP 13 1984	
					25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



## MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23537			
1. FOR STATE REGISTRAR				1. DECEASED NAME FIRST MIDDLE LAST Emma CHRISTINE COTTON (FARROW)			
2a. DATE OF DEATH MONTH DAY YEAR September 28, 1984				2b. HOUR AM PM 8.10 AM			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 06 27 13		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS 71 YRS. MONTHS 3 DAYS 1 HOURS - MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 2870 W. Mulberry St. 21223							
14. FATHER'S NAME FIRST MIDDLE LAST Archie Bridges				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Bridges			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 243-07-3086		17. INFORMANT ADDRESS Cammie Langley 2870 W. Mulberry St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>POSSIBLE MYOCARDIAL INJURY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA INFECTION</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>"MINOS"</u> <u>"DAYS"</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>WITH PORTAL HYPERTENSION, POST HEPATITIS CIRRHOSIS OF LIVER, RENAL INSUFFICIENCY, GANGRENOUS GALL BLADDER WITH PUS</u>							
19a. DATE OF OPERATION 9/15/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED VERY POOR RISKS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. 9/27/84 to 9/28/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. CHANARANG MD				22e. ADDRESS 1905 YORK ROAD TIMONION MD 21093			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 10/2/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk. Arbutus,		23d. LOCATION COUNTY Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Ave.				25a. DATE REC'D. BY REGISTRAR OCT 1 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1. The purpose of this document is to provide information regarding the activities of the [redacted] in the [redacted] area.



2. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

3. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

4. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

5. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

6. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

7. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

8. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

9. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

10. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

11. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

12. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

13. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

14. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.

15. The [redacted] has been observed in the [redacted] area, and it is believed that the [redacted] is involved in the [redacted] activities.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23538

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ALBERTINE H. CRAWFORD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 3, 1984</b>		2b. HOUR <b>2:50 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 29 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>
13a. STATE <b>MD.</b>		13b. COUNTY <b>-</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN BLADES</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-48-6763</b>		17. INFORMANT ADDRESS <b>CHAS. ARMETTA 1605 DENNIS AVE. 21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line 1a (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>50 minutes</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cor Pulmonale</b>					<b>3 years</b>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Atrial fibrillation, Hypertensive arteriosclerotic cardiovascular disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>August 12, 1984</b> to <b>September 3, 1984</b> , that (I) (we) last saw the deceased alive on <b>Sept. 3, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Patricia A. Savadel</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/3/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATRICIA A. SAVADEL</b>		22e. ADDRESS <b>7600 OSLER DRIVE SUITE 200 TOWSON MD 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/7/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PK. BALTO.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>					
24. FUNERAL DIRECTOR'S NAME <b>SCHIMUNEK FUNERAL HOME, INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 5 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia A. Savadel</b>	
25c. ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FORWARDED TO CHAIRMAN WHITE

THE CHAIRMAN

THE CHAIRMAN

THE CHAIRMAN

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		2 3 5 3 9		
1. DECEASED NAME (TYPE OR PRINT) CLARA M. CROCKETT			2a. DATE OF DEATH MONTH DAY YEAR 9-27-84			
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 29 1897	
6. AGE (IN YEARS LAST BIRTHDAY) 87			7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			9b. CITY OR TOWN OF DEATH Randallstown		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hosp.	
11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk	
14. FATHER'S NAME FIRST MIDDLE LAST Humphrey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie V. Cross		16. SOCIAL SECURITY NO. 216-24-0354	
17. INFORMANT Louise R. Leonard			18. ADDRESS 2751 Moorgate Road Balto. MD		19. ZIP CODE 21222	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) CVA ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from 9-23-84 to 9-27-84, that (I) (we) last saw the deceased alive on 9-23-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Rayadurg G. Rao		DEGREE		22c. DATE SIGNED 9-27-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYADURG G. RAO		22e. ADDRESS BALT COUNTY GNL HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/29/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		
23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Maryland		23f. STATE Maryland		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		24b. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222		25. DATE REC'D BY REGISTRAR OCT 1 1984		
25a. REGISTRAR'S SIGNATURE [Signature]		25b. REGISTRAR'S SIGNATURE [Signature]				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1. FOR STATE REGISTRAR		Item #17 Film #G595 9/19/84 jp		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 64 23540	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES FRANK CROMWELL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9/14/84</b>		2b. HOUR <b>10:28<sub>AM</sub></b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 27 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>76</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N CHARLES ST GBMC</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Phoenix</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Andrew Cromwell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Lee Warfield</b>		13e. STREET ADDRESS / ZIP CODE <b>14610 Manor Road 21131</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>125-10-2120</b>		17. INFORMANT <b>Jane C. Mrs. Cromwell - Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MIN YEARS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>9/14</b> , 19 <b>84</b> , to <b>9/14</b> , 19 <b>84</b> , that (1) (we) last saw the deceased alive on <b>9/14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. M Magram</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-14-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. M MAGRAM</b>		22e. ADDRESS <b>7600 OSLER DR SUITE 113 BALTO MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>9/15/84</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Davidson</i>	

BP

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-20 BY 60322 UCBAW/STP

10:10:20

BALTIMORE COUNTY

STATION 1001 CHARLES ST BALTO

ROUTE 1001 CHARLES ST BALTO

ROUTE 1001 CHARLES ST BALTO

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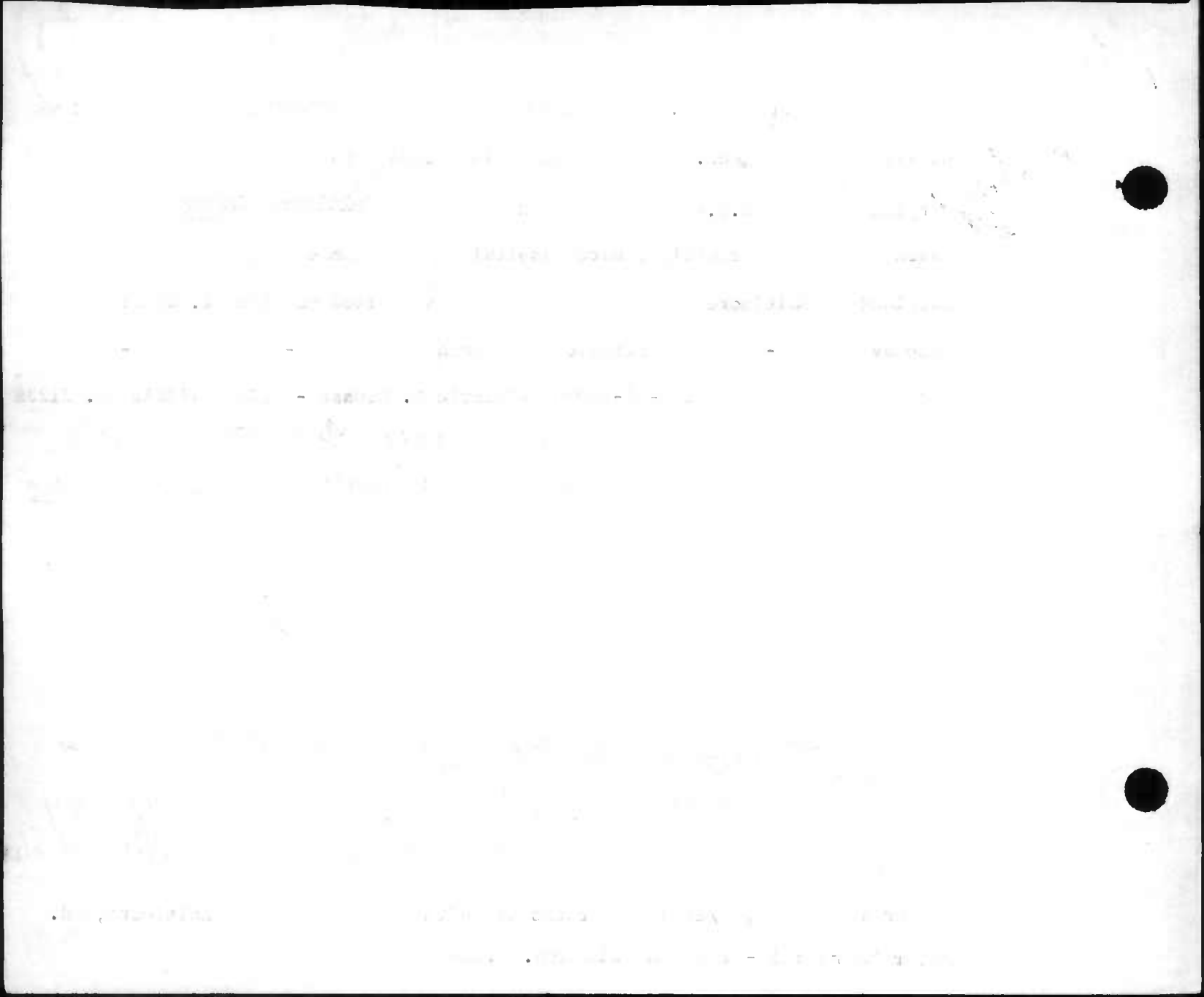
10:10:20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										23541	
1 - FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lillian H. Crusse					2a. DATE OF DEATH MONTH DAY YEAR September 17, 1984					2b. HOUR 10:34a	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 08 16 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS DAYS - -		8. IF UNDER 74 HRS HOURS MIN. - -	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas - Hartlove					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma -						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-1692D		17. INFORMANT ADDRESS Victoria D. Crusse - 1235 Hilldale Rd. 21234							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (the hospital) attended the deceased from <u>January 22, 1981</u> to <u>PRESENT</u> 19 <u>84</u> that (I) <u>did</u> not saw the deceased alive on <u>August 26, 1984</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> not view the body after death.											
22a. SIGNATURE <u>E. Weisbrod</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/18/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Weisbrod				22e. ADDRESS 406 Eastern Blvd. Balto., Md. 21224							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/20/1984		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME Walter Dabrowski - 1005 Dundalk Ave. 21224				25a. DATE REC'D. BY REGISTRAR SEP 21 1984		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Robell</u>					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 3 5 4 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Paul C Cunzeman Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-1-84</b>		2b. HOUR <b>2:45 A</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3-24-1909</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. City</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Baltimore County MD</b>
10. CITY OR TOWN OF DEATH <b>Essex</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Balto City Fire Dept-</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Wm. Cunzeman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Lloyd</b>		13e. STREET ADDRESS / ZIP CODE <b>8031 Highpoint Rd. -21234</b>		Retired
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-24-4177</b>		17 INFORMANT ADDRESS <b>Mrs. Florence C. Cunzeman</b> <b>8031 Highpoint Rd. -21234</b>		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive Heart Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8-19 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8-19</b> 19 <b>84</b> , to <b>9-1</b> 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9-1</b> 19 <b>84</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Thomas Lampone</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/1/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Lampone</b>				22e. ADDRESS <b>9000 Franklin Square Dr. 21237</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-4-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>	
24 FUNERAL DIRECTOR <b>John C. Miller Inc.-6415 Belair Rd. 21206</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 5 1984</b>			

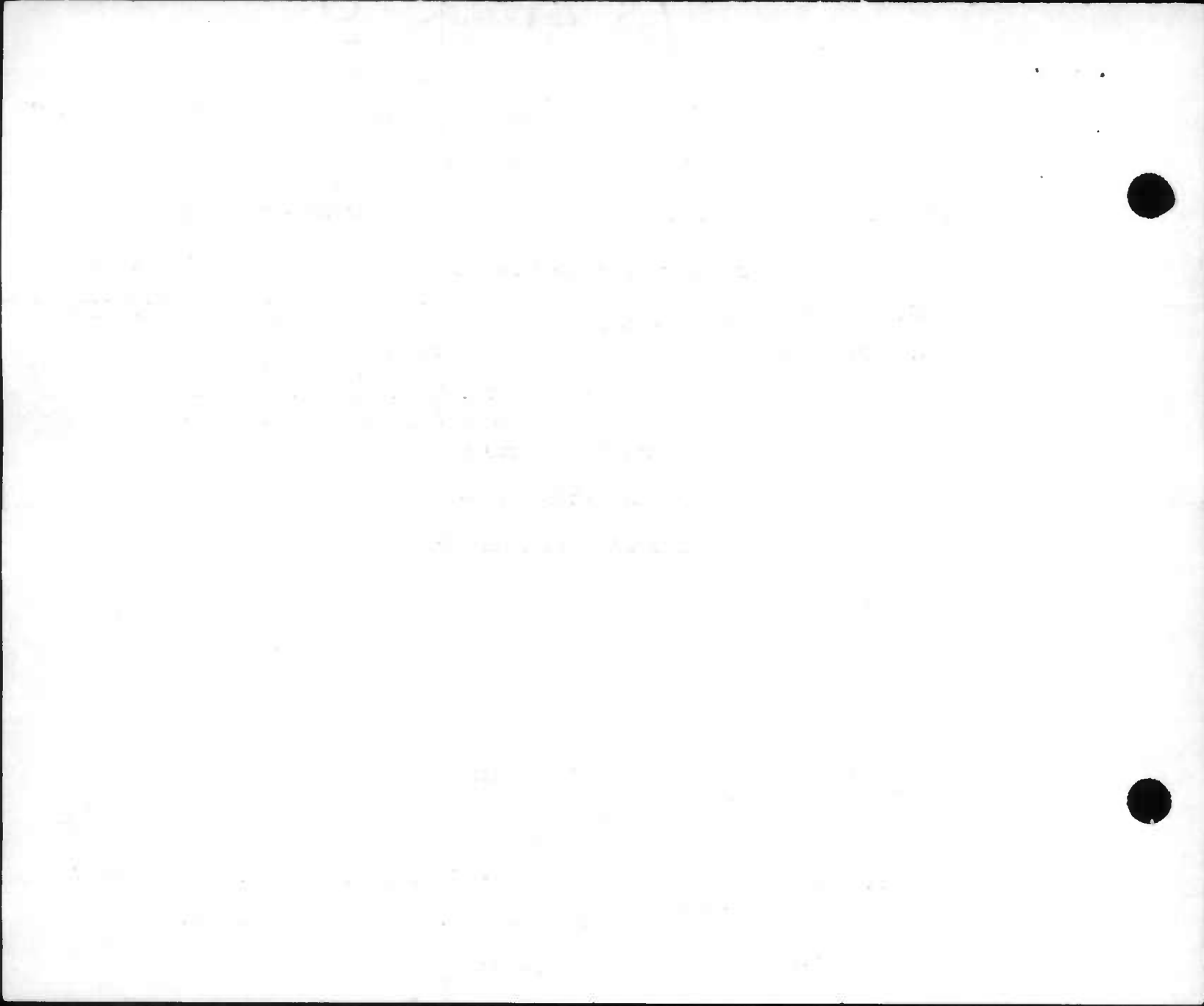
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>William J. Cusick</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 17 84</b>			2b. HOUR <b>5:38 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 4 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS Hospice</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Turbine Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. G. &amp; E.</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b>			13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Balto., Md. 4007 Frederick Ave. #21229</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. Cusick</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Theresa Albecker</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>212-05-3598</b>			17. INFORMANT <b>Marie E. Cusick</b>			ADDRESS <b>Balto., Md. 4007 Frederick Ave. #21229</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>RETROPERITONEAL CARCINOMA, PROBABLE germ cell</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>September 12, 1984</b> to <b>September 17, 1984</b> , that (I) (we) last saw the deceased alive on <b>September 17, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. Faulkner MD</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9-21-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR NAME <b>G. Truman Schwab</b>						ADDRESS <b>3512 Frederick Ave. #21229</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1984</b>	
						25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ida Elizabeth DAVIS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 7, 1984</b>		2b. HOUR <b>10:45</b> AM		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 14, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY <b>Maryland</b> <b>Baltimore</b>					13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Pohlman</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Schwartz</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-32-1934</b>		17. INFORMANT <b>Charles D. Davis</b>		ADDRESS <b>3305 Beech Ave. Baltimore, Md. 21211</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE CEREBRAL DYSFUNCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBRAL VASCULAR ACCIDENT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CITING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>AUGUST 27, 1984</b> to <b>SEPTEMBER 7, 1984</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>SEPTEMBER 7, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen G. Hickey MD</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>9/7/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN HICKEY, MD.</b>					22e. ADDRESS <b>9000 FRANKLIN SQUARE DR., 21237</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 10, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Balt. Cty. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>A. Alan Seitz, Jr. Funeral Home Balt, Md. 21211</b>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>SEP 11 1984</b> <b>John Davidson-Randall</b>				

RECEIVED BY THE  
OFFICE OF THE  
TREASURER OF THE  
UNITED STATES



*Robert M. [illegible]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Elfriede F. Dawson</b>			2a. DATE OF DEATH MONTH <b>Sept</b> DAY <b>19</b> YEAR <b>1984</b>			2b. HOUR <b>7:17am</b>	
3. SEX <b>Female.</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Jan</b> DAY <b>29</b> YEAR <b>1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>West Germany</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Randallstown</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H-W.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodlawn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Emil</b> MIDDLE <b>Lang</b> LAST <b></b>		15. MOTHER'S MAIDEN NAME FIRST <b>Josephine</b> MIDDLE <b>Helene</b> LAST <b>Nink</b>		13e. STREET ADDRESS / ZIP CODE <b>2686 West Park Drive 21207</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-26-4862</b>		17. INFORMANT <b>Mr. Charles Lester Dawson, Jr.</b> <b>2686 West Park Drive Baltimore, MD. 21207</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**ACUTE MYOCARDIAL INFARCTION**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**Sudden.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**DIABETES MELLITUS****OLD****MYOCARDIAL INFARCTION**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. **19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME STREET FACTORY OFFICE FARM ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **October** 19 **69** to **Sept** 19 **84**, that ~~he~~ (we) last  
saw the deceased alive on **SEPT 19 84**, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated  
above, ~~he~~ (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING ☒ MEDICAL ☐ STAFF  
PHYSICIAN DIRECTOR PHYSICIAN

22c. DATE SIGNED

**SEPT. 19, 1984**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**HERMAN BRECHER, M.D.****6410 WINDSOR MILL RD.****21207**23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) **Burial**23b. DATE  
**9/22/84**23c. NAME OF CEMETERY OR CREMATORY  
**Lorraine Park Cemetery**23d. LOCATION  
CITY OR TOWN**Baltimore Md.**

STATE

24. FUNERAL DIRECTOR

**Loring Byers Funeral Directors, Inc.**

25. DATE REC'D BY REGISTRAR

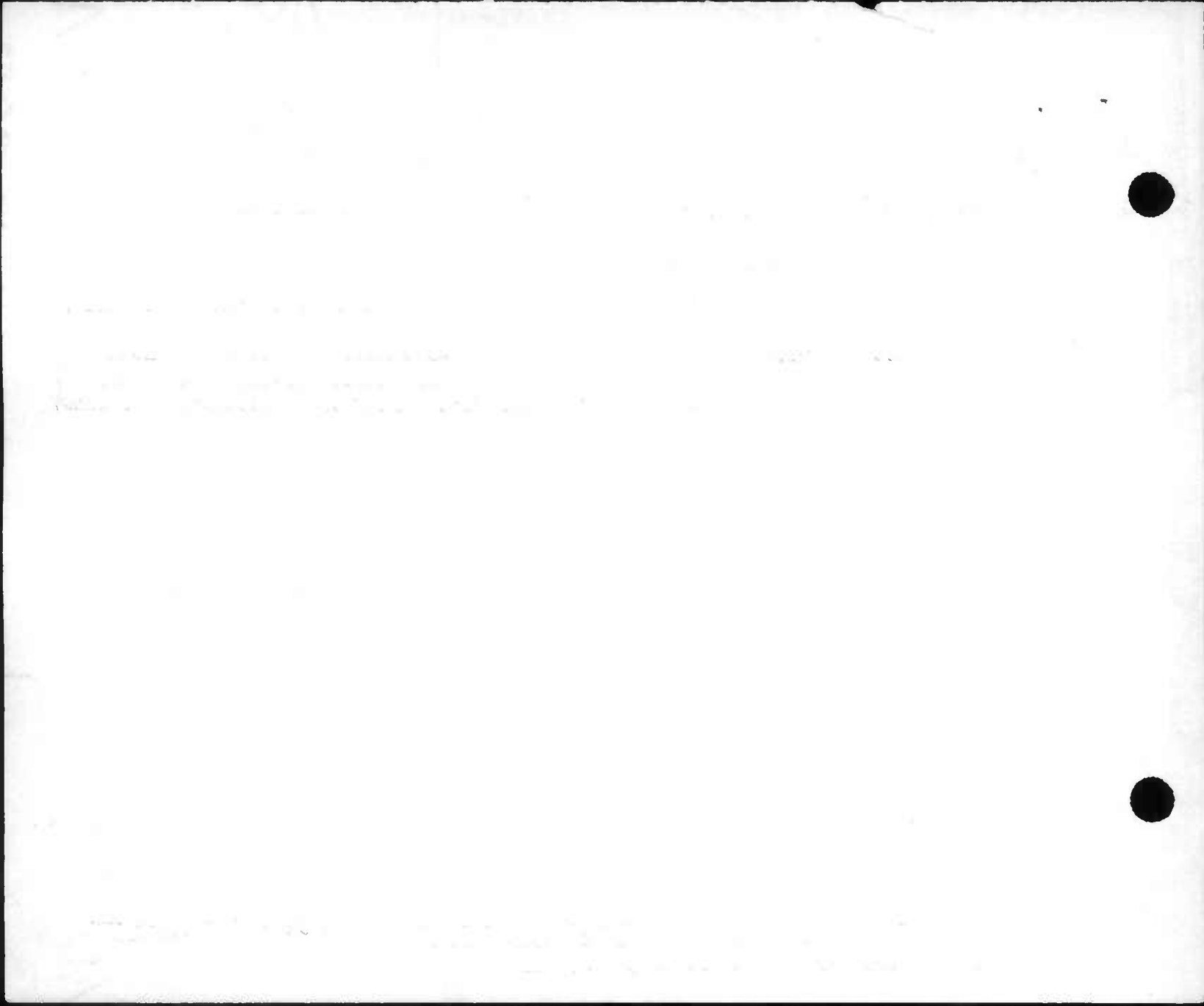
26. REGISTRAR'S SIGNATURE

**8728 Liberty Road Randallstown, MD. 21133****SEP 21 1984****Twicken-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23546

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert</b> <b>ROBERT</b> <b>LAWRENCE</b> <b>DEAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-22-84</b>		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 19, 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry C. Dean</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret E. Hagan</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	
16b. SOCIAL SECURITY NO. <b>705-05-7466</b>		17. INFORMANT ADDRESS <b>Daniel O'Donnell -707 Saylor Ct., Towson, Md.</b>		21204	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Chronic Obstructive Pulmonary Disease**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>7-1-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-1-83</b> 19 <b>83</b> , to <b>9-22</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9-22-84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R. Faulkner MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-22-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kendall R. Faulkner</b>		22e. ADDRESS <b>Dulaney Valley Rd Towson, Md. 21204</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-27-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>		ADDRESS <b>1050 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>SEP 26 1984</b>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23547

1. DECEASED NAME (TYPE OR PRINT) <b>BROTHER ANTHONY J. DEINLEIN S.M.</b>				2a. DATE OF DEATH MONTH <b>9</b> DAY <b>12</b> YEAR <b>84</b>				2b. HOUR <b>12:20</b> AM	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>21</b> YEAR <b>07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS HOSPICE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>EDUCATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HIGH SCHOOL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1001 S. CATON AVENUE, 21229</b>	
14. FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b>---</b> LAST <b>DEINLEIN</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b>---</b> LAST <b>STAAB</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>284-48-6020</b>				17. INFORMANT <b>BRO. FRANCIS SCHROEPFER, S.M.</b>				ADDRESS <b>1001 S. CATON AVE. 21229</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYNPHOMA, DIFFUSE HISTIOCYTIC</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/31</b> , 19 <b>84</b> , to <b>9/12</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9-11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. Faulkner MD</b>						DEGREE		22c. DATE SIGNED <b>9/12/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FAULKNER, M.D.</b>						22e. ADDRESS <b>c/o STELLA MARIS HOSPICE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>09-14-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART OF JESUS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DUNDALK BALTIMORE MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS <b>21229 4107 WILKENS AVE.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP \_\_\_\_\_

(A)



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 4 8

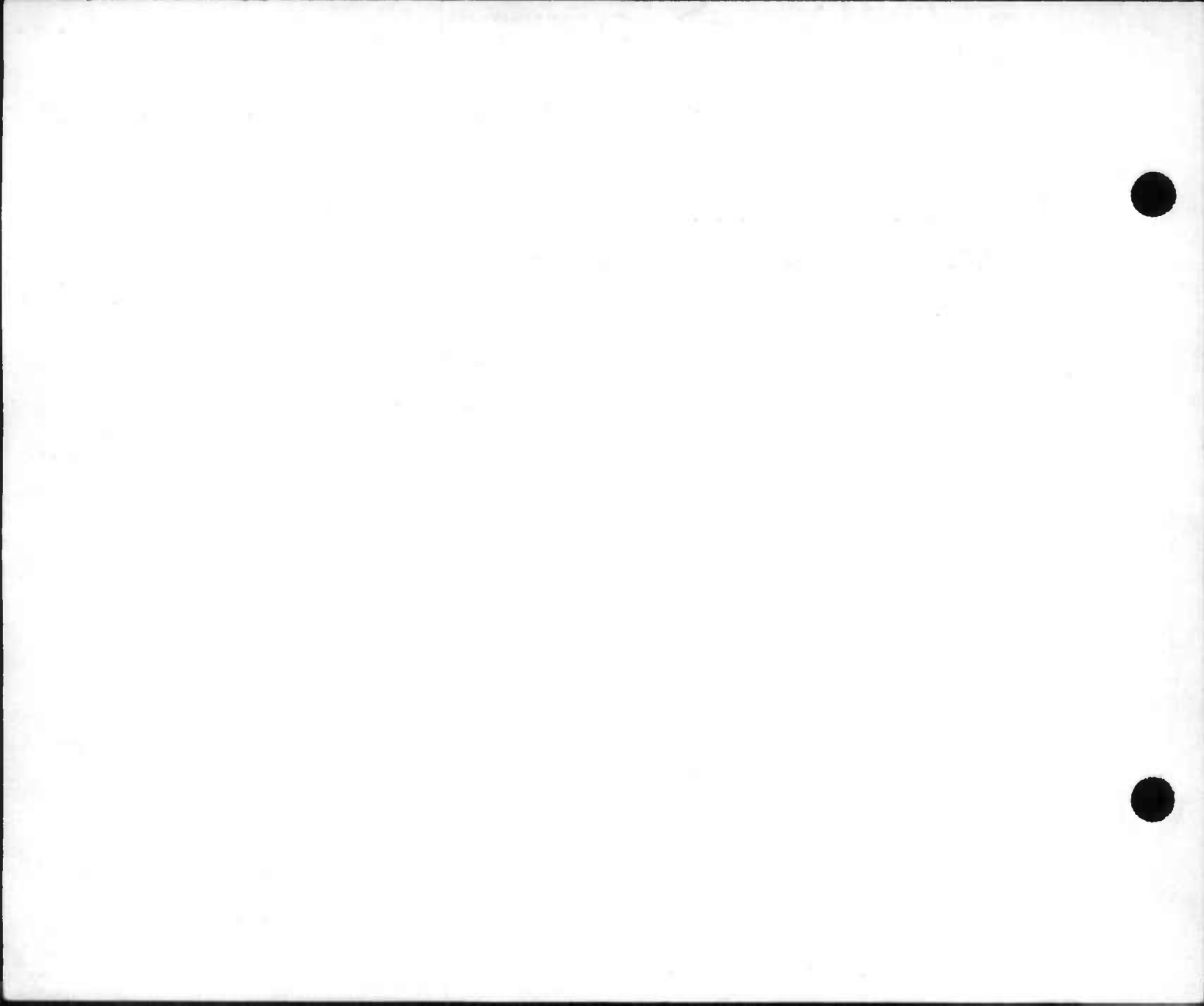
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELSIE M. DEVER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 8, 1984</b>			2b. HOUR <b>3:45 A.M.</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 27, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Zolliecoffer Van Hooiser</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Drucilla Cantral</b>		16. STREET ADDRESS / ZIP CODE <b>1907 Wildwood Ave. 21234</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-18-5286</b>		17. INFORMANT ADDRESS <b>Van D. Dever 8027 Dalesford Rd. 21234</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Right Middle Lobe Pneumonia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b> <b>years</b> <b>9 days</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Supraventricular Tachycardia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 29, 1984</b> to <b>Sept. 8, 1984</b> , that (I) (we) lost saw the deceased <b>above</b> <b>Sept. 8, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <b>F. Wiegmann</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED <b>9/8/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F. WIEGMANN</b>		22e. ADDRESS <b>8406 HARFORD RD. / BALTIMORE, MD. 21234</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 10, 84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Of Jesus Cem. Baltimore, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. 5305 Harford Rd. 21214</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randell</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a necropsy performed.



10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B showing injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

1 - FOR  
STATE  
REGISTRAR

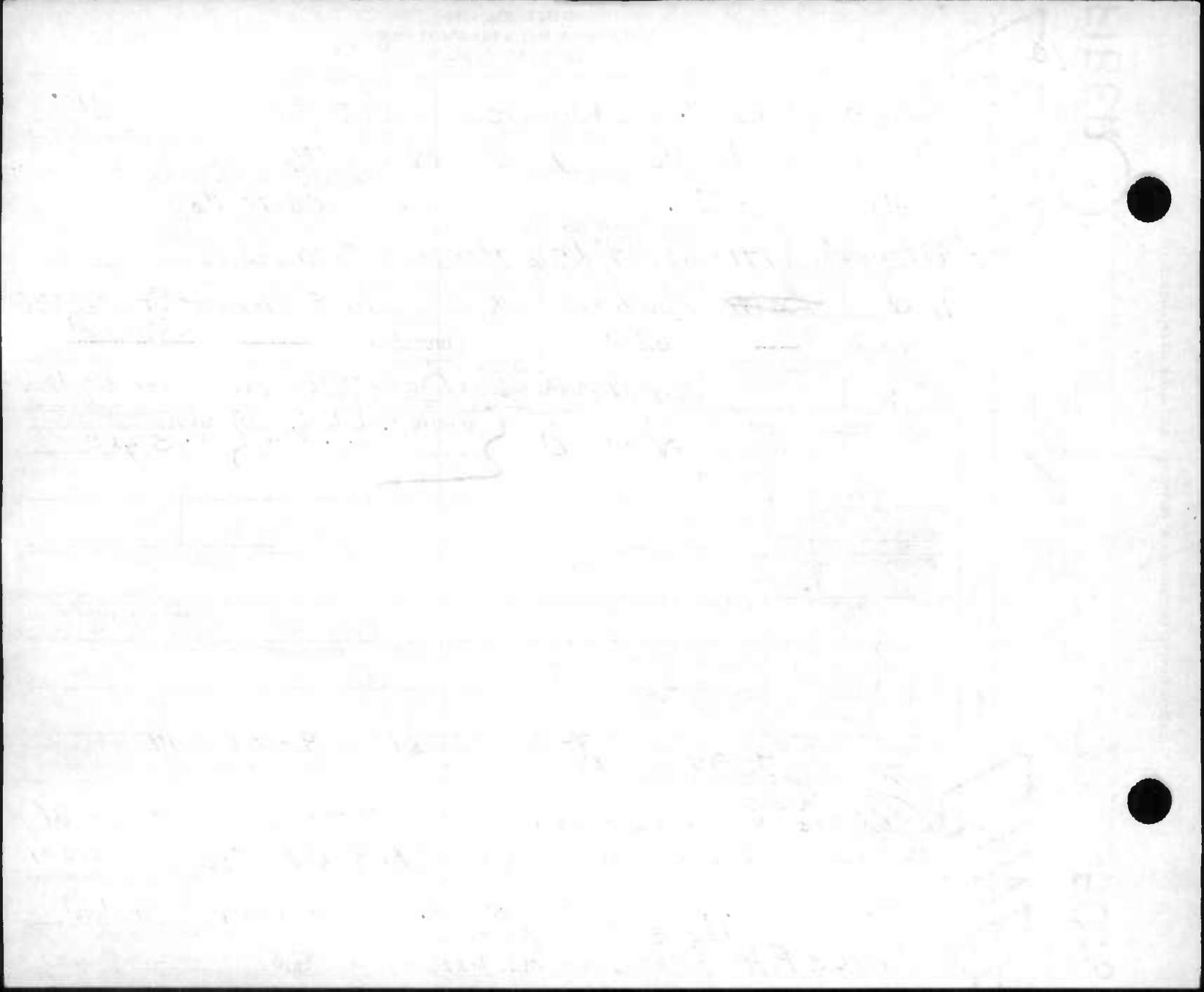
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 23549

1. DECEASED NAME (TYPE OR PRINT) <b>Christopher J. DiBlasi</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-30-84</b>		2b. HOUR <b>11:10 P.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1-27-09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Armacost Vsg. Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seaman</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>			13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph DiBlasi</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Concetta Ciaramunti</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-18-4337A</b>		17. INFORMANT ADDRESS <b>Jane Barrett R.O. Armacost Vsg Home</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8-3</b> , 19 <b>81</b> to <b>9-30</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9-29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) revive the body after death.						
22b. SIGNATURE <b>Charles O'Donnell</b> DEGREE _____				22c. DATE SIGNED <b>9-30-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Charles O'Donnell</b>				22e. ADDRESS <b>7501 YORK Rd. Towson 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 4, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemt.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR NAME <b>McCully's F.H.</b> ADDRESS <b>130 E Balto Fort Ave md. 21230</b>				
25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>				

MEDICAL CERTIFICATION

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		CORNELIA K. DIEHLMANN				REG. NO. 23550			
1. DECEASED NAME (TYPE OR PRINT) <b>Cornelia K. Diehlmann</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>09-22-84</b>			2b. HOUR <b>1:55 A.M.</b>	
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 24, 1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Summit Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Owm Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>114 Smithwood Road 21228</b>	
FATHER'S NAME FIRST MIDDLE LAST <b>Louis William Hoffman</b>		MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>May Dorothy Stallneht</b>							
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		14b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-18-7722 D</b>		17 INFORMANT ADDRESS <b>Phylliss Holtman Same as # 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:11-77 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>511-77 19 to 9-22-84</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-21-84</b> 19 <b>9-22-84</b> 19 <b>9-22-84</b> that (I) (we) lost saw the deceased alive on <b>9-21-84</b> 19 <b>9-22-84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>George Angel</b>		DEGREE				22c. DATE SIGNED <b>9-22-84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE ANGOL</b>		22e. ADDRESS <b>3350 Wilkins Dr. Bldg. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>9/25/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Mausoleum</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Md.</b>			
24. FUNERAL DIRECTOR <b>LeRoy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> 1630 Edmondson Avenue, Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

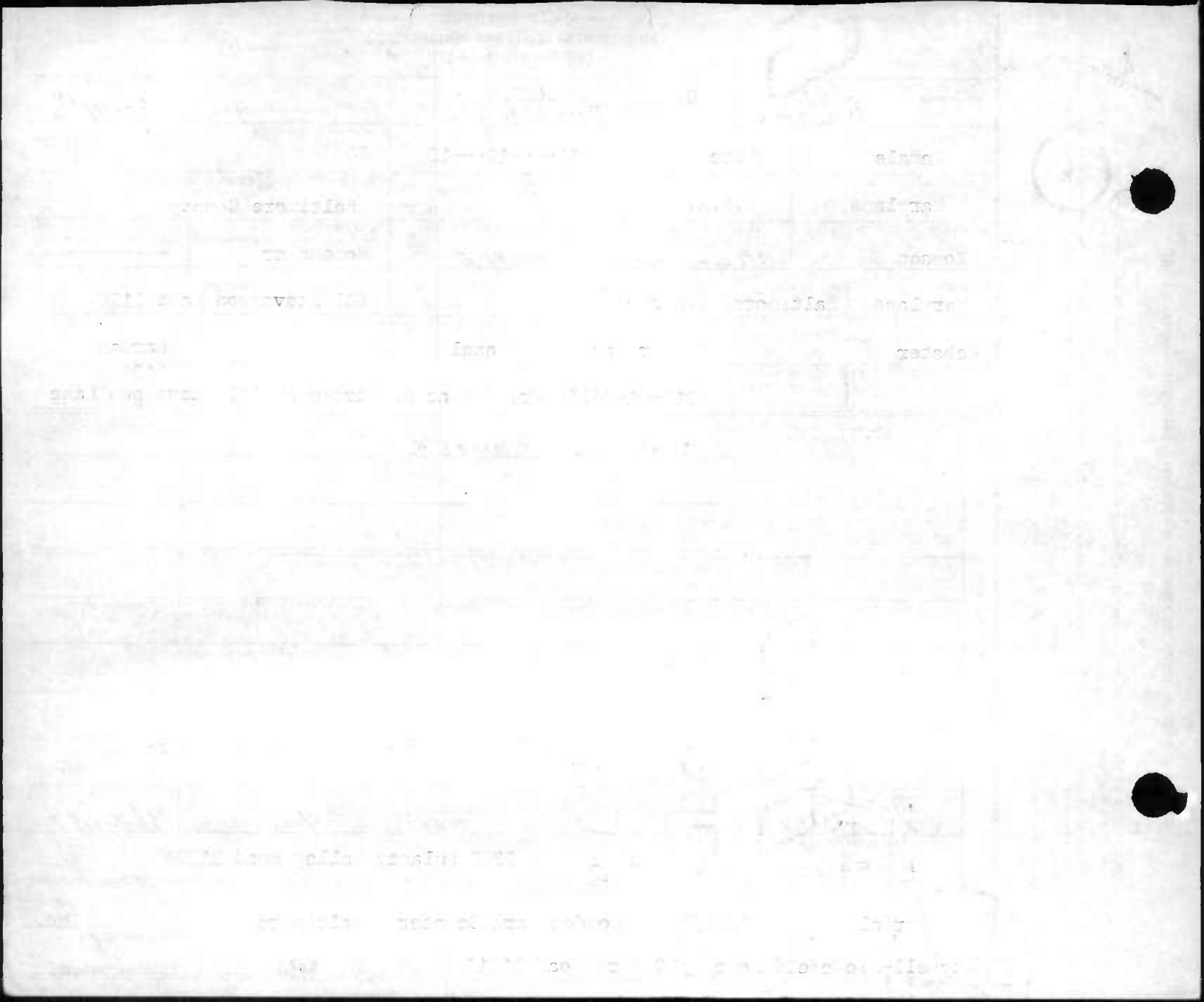
REG. NO.

23551

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY C. DiGIORGIO</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9-26-84</b>				2b. HOUR <b>11<sup>18</sup> A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-12-13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS HOSPICE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>807 Stevenson Lane 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Webster Erdman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hazel Harman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>212-01-6450</b>		17. INFORMANT <b>Mr. Thomas A. Strohm IV</b>				ADDRESS <b>807 Stevenson Lane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OVARIAN CANCER</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/28</b> , 19 <b>84</b> , to <b>9/26</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/24</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>K. Faulkner MD</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>9/26/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. FAULKNER M.D.</b>				22e. ADDRESS <b>2300 Dulaney Valley Road 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/29/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 York Road 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 2 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Johia Davidson-Randall</b>	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Di Julio			2a. DATE OF DEATH MONTH DAY YEAR September 26, 1984			2b. HOUR 6:59 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 3, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 104 La Paix Lane		12a. USUAL OCCUPATION Homebuilder and Developer		12b. KIND OF BUSINESS OR	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 104 LaPaix Lane 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Carlantonio Di Julio				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Filomena DiTillio			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-22-4696		17. INFORMANT ADDRESS Mrs. Anna J. Di Julio 104 LaPaix Lane 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPSIS.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>STROKE.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>SEVERE Emphysema.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>approx 7 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9.25.84</u> , 19 <u>84</u> to <u>9.26.84</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>9.26.84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Aye Lwin</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR PHYSICIAN		22c. DATE SIGNED 9.27.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aye Lwin.				22e. ADDRESS 805. DARTMOOR RD. LUTHERVILLE MD. 21093.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 10-1-1984		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home Inc. Towson, Maryland				ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR SEP 28 1984	
				25b. REGISTRAR'S SIGNATURE <u>Jana Davidson-Rendell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>John F. DOBRZYCKI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 26, 1984</b>		2b. HOUR <b>7:55<sup>A</sup> M</b>	
3. SEX <b>Male</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 24 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD		
10. CITY OR TOWN OF DEATH <b>Essex</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lumber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Dundalk</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John - Dobrzycki</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann -</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-01-2665</b>		17. INFORMANT ADDRESS <b>Mr. John T. Dobrzycki - 6817 Youngstown Ave 21222</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>SMALL CELL CARCINOMA OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF } (c) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 23, 1984</b> to <b>SEPTEMBER 26, 1984</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>SEPTEMBER 26, 1984</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Lester H. Banks</i>		DEGREE <b>PHYSICIAN</b>		22c. DATE SIGNED <b>September 26, 1984</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LESTER BANKS, M.D.</b>		22e. ADDRESS <b>9000 FRANKLIN SQUARE DR., 21237</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/29/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Walter Dabrowski - 1005 Dundalk Avenue 21224</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>		
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 23554

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM J DOCIMO Sr.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9 30 84</b>		2b. HOUR <b>12<sup>55</sup> PM</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 16 14</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		7. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		10. CITY OR TOWN OF DEATH <b>Randallstown</b>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tailor</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8606 Bramble Lane T4 21133</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph Docimo</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Letizia Letti</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	
16b. SOCIAL SECURITY NO. <b>W. W. II 202-22-8135</b>		17. INFORMANT <b>Sylvia Docimo</b>		ADDRESS <b>8000 Bramble Lane T4</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CARDIOGENIC SHOCK - RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE MYOCARDIAL INFARCTION</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		9c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/27 1984</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/27 1984</b> to <b>9/30 1984</b> , that (I) (we) last saw the deceased alive on <b>9/30 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. R. Depestre</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/30/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. DEPESTRE</b>		22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSP.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>October 2, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>10-4-84</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, INC. 8728 Liberty Rd. Randallstown, MD 21133-4784</b>		25. REGISTRAR'S SIGNATURE			



7/10/1940



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 5 5

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nora T. Dohoney			2a DATE OF DEATH MONTH DAY YEAR 09 21 84		2b HOUR 11:55 P M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 03 27 98	6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Multi Medical Nursing Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.	13b. COUNTY Balto	13c. CITY OR TOWN Riderwood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS Riderwood 21139 7926 Roldrew Ave	
14 FATHER'S NAME FIRST MIDDLE LAST John J Dohoney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A Walsh			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO 213-50-0928	17 INFORMANT John J. McGrath ADDRESS Same /		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resp. failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last (b) <u>Resp. col. h. dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 d. years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Squam. cell ca stomach &amp; esoph. stricture</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from <u>9/24/84</u> 19 <u>84</u> to <u>9/21/84</u> that (1) (we) last saw the deceased alive on <u>9/21/84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b SIGNATURE Philip Whittlesey M.D.		DEGREE M.D.		22c DATE SIGNED 9/24/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Philip Whittlesey M.D.		22e ADDRESS 600 W. Northern Parkway			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/25/1984	23c NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d LOCATION Baltimore COUNTY MD STATE
24 FUNERAL DIRECTOR NAME Mitchell-Wiedefeld HOME		ADDRESS 6500 York Rd.		25a DATE REC'D. BY REGISTRAR SEP 26 1984	
		25b REGISTRAR'S SIGNATURE Jana Davidson-Randall			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELBRIDGE</b>		FIRST <b>B.</b>		MIDDLE <b>DONALDSON</b>		LAST <b>DONALDSON</b>		2a. DATE OF DEATH MONTH <b>9</b> DAY <b>27</b> YEAR <b>'84</b> 5:10A <b>M</b>							
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>Mar.</b> DAY <b>26,</b> YEAR <b>1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		7b. HOUR <b>5:10A</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.									
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney</b>		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6012 Hunt Ridge Rd. - 21210</b>							
14. FATHER'S NAME FIRST <b>Elbridge</b> MIDDLE <b>B.</b> LAST <b>Donaldson, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Rosalie</b> MIDDLE <b>Gladfelter</b> LAST <b>Gladfelter</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>212 09 2551A</b>		17. INFORMANT ADDRESS <b>Mrs. Buelah B. Donaldson 6012 Hunt Ridge Rd.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>GASTRO INTESTINAL BLEED</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> , 19 <b>84</b> , to <b>9/27</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/27</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <b>D. Pappas MD</b>		22c. DATE SIGNED <b>9/27/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. PAPPAS, MD.</b>				22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9/29/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>									
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME, INC.</b> ADDRESS <b>6500 York Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 2 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>									

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1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 25

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1- FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Leonard B. Downey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/4/84</b>			2b. HOUR <b>250 AM</b>				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 17 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co. MD</b>				
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care - Rossville</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sheriff</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>ROSSVILLE</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>318 LORRAINE AVE. 21221</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>EMORY Downey</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY DONNELLY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNK</b>			16b. SOCIAL SECURITY NO. <b>213-07-2920</b>		17. INFORMANT ADDRESS <b>MARGARET DOWNEY ABOVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypoxic encephalopathy</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cirrhosis of the liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b> <b>years</b>		
								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>Chronic GI bleeding</b>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug-28</b> 19 <b>84</b> , to <b>Sept-4</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Aug 28</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. Matos</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9/4/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. MATOS</b>					22e. ADDRESS <b>21 CRANBROOK RD. COCKEYSVILLE, MD 21030</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>9/6/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DAK LAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME <b>J.G. CONNELLY</b>					ADDRESS <b>300 MACE</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mostly centered and spans most of the page area.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 4 2 3 5 5 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

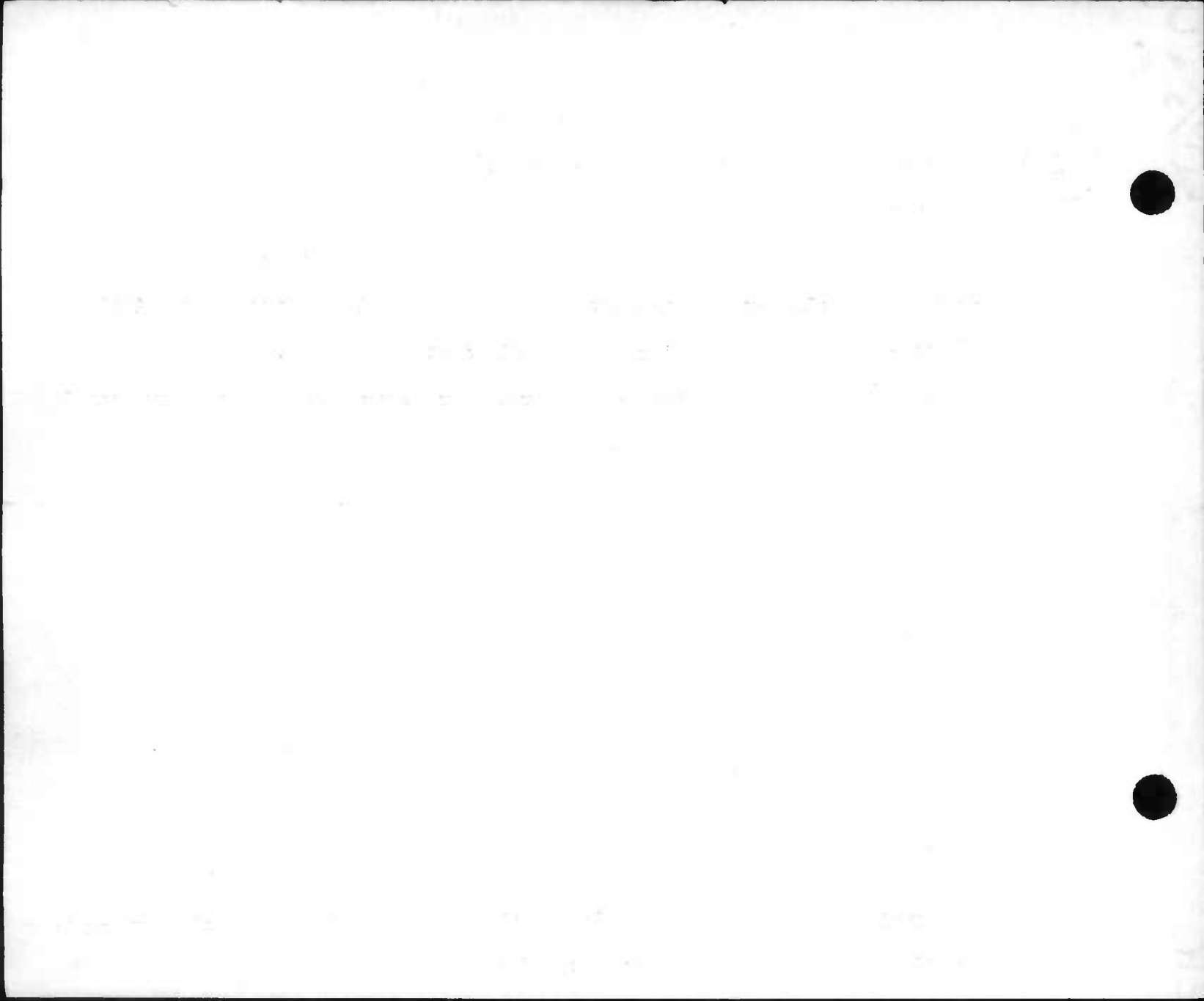
1. DECEASED NAME (TYPE OR PRINT) FIRST: GRACE MIDDLE: HELEN LAST: BOYLE			2a. DATE OF DEATH MONTH: 9 DAY: 30 YEAR: 84 2b. HOUR: 3:45 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH: June DAY: 09 YEAR: 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. MONTHS: DAYS: HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.
10. CITY OR TOWN OF DEATH Towson Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 418 Dumbarton Road 21212
14. FATHER'S NAME FIRST: William MIDDLE: O'Brien		15. MOTHER'S MAIDEN NAME FIRST: Elizabeth MIDDLE: Gempp		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-20-9550		17. INFORMANT ADDRESS Mrs. Henry Curlander 8414 Saunders Road 21093
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b): DUE TO, OR AS A CONSEQUENCE OF (c):				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 10/10, 19 80, to 10/30, 19 84, that (I) (we) last saw the deceased alive on 9/28, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Eddie Nakhuda		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eddie Nakhuda		22e. ADDRESS Dulaney Valley Rd Towson, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-5-84	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR OCT 2 1984 25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

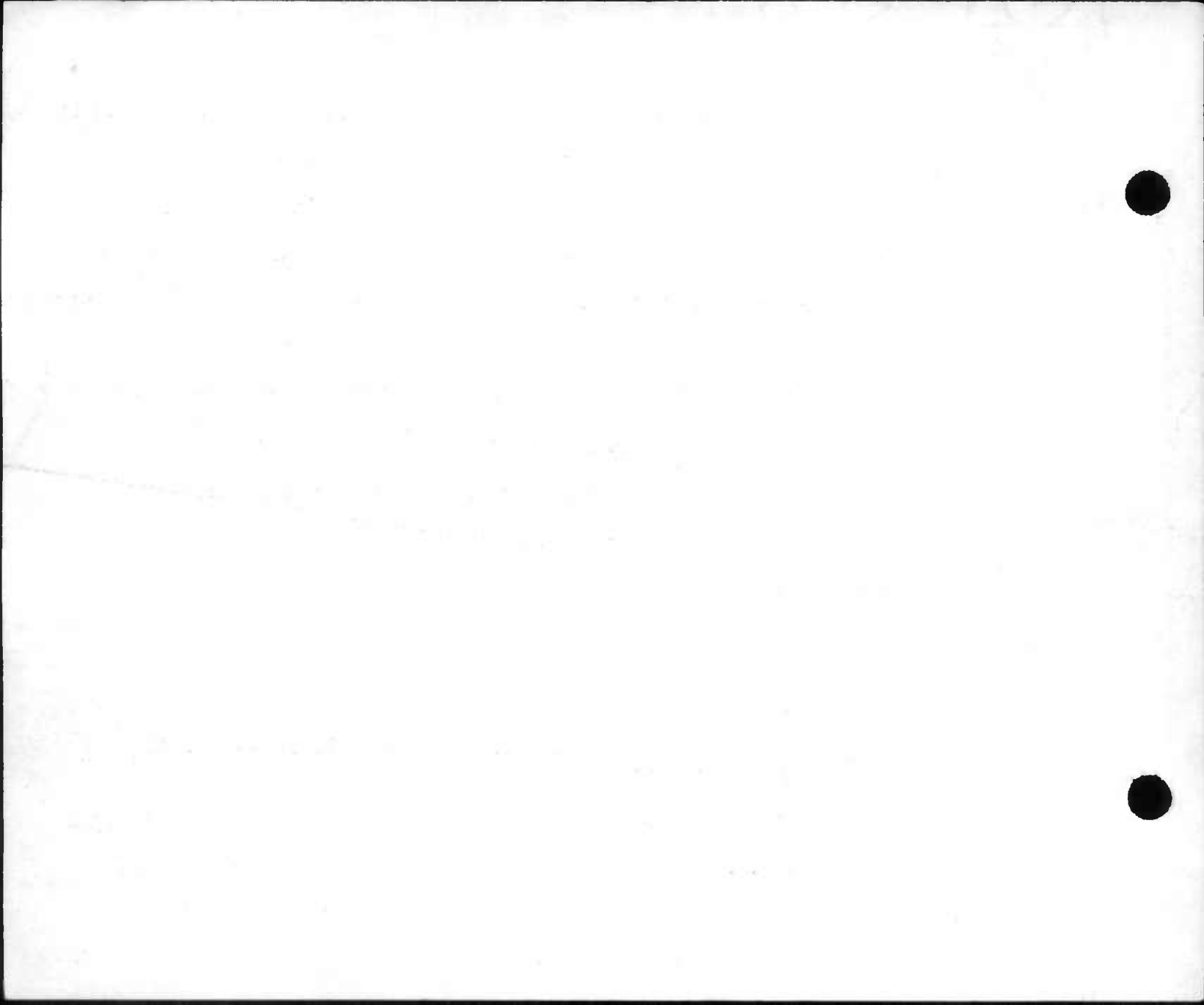
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1- FOR STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Emma Elizabeth DRISCOLL		September 23, 1984		9:35A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female	Caucasian	12-25-1904		79 yrs.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.	USA			Baltimore County, MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Franklins Square Hospital		Factory Work		Bendix
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Md.		Baltimore	Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
George Reed		Catherine Huber		4245 E. Joppa Road 21236	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		214-22-4290		Marlene Balliet Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Respiratory Failure					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) Recurrent Pulmonary Edema; Cardiogenic Shock					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Anterior Myocardial Infarction					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Acute Renal Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from August 30, 1984, to September 23, 1984, that (X) (we) lost the deceased on September 23, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
K. Mason, MD				9/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Karen Mason, M.D.		9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9-26-84		Parkwood Cemetery	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Balto., Md.		SEP 25 1984		[Signature]	
24. FUNERAL DIRECTOR					
Schimunek Funeral Home, Inc. 9705 Belair Road, Balto., Md. 21236					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 5 6 0

REG. NO.

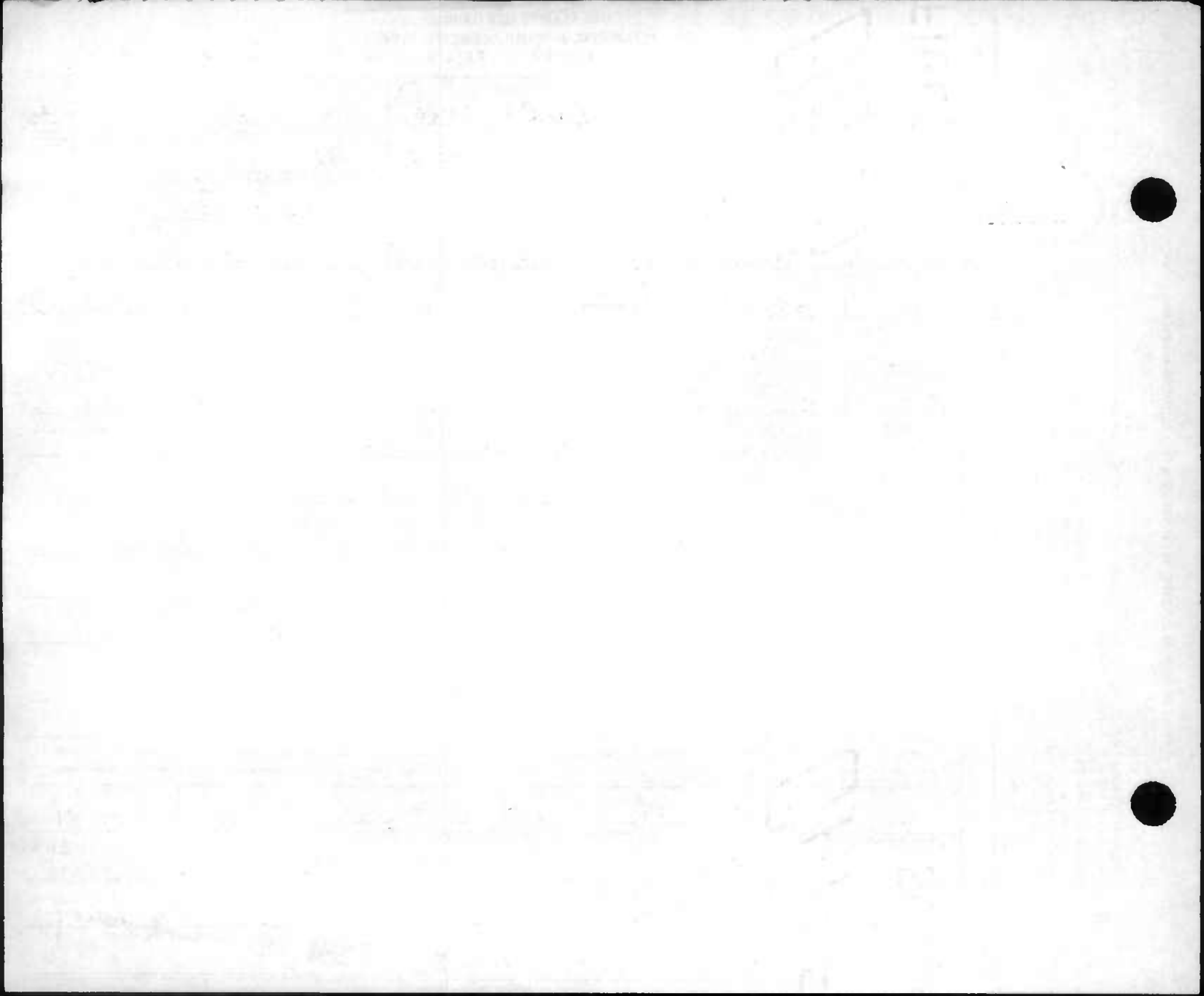
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>ANNA</u> <u>DURA</u> <u>(DURO)</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>9-4-1984</u>		2b. HOUR <u>8:00 AM</u>		
1. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>3-15-1893</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <u>91</u> <u>9</u> <u>19</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Lithuania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore Co.</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) <u>Valley Nursing + Convalescent Center</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Seamstress</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Electing Co.</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>?</u> <u>Markunas</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>unknown</u>		13e. STREET ADDRESS / ZIP CODE <u>1815 Kentworth Rd. 21234</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>713-28-2945A</u>		17. INFORMANT ADDRESS <u>Stanley Dura 1815 Kentworth Rd. 21234</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic CARDIOVASCULAR Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senescence</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>11a</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>G. O. MANKO</u>		22c. DATE SIGNED <u>9-4-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G. O. MANKO</u>		22e. ADDRESS <u>11722 Reisterstown Rd, Reisterstown 21136</u>	

23a. BURIAL, CREMATION, REMOVAL (TYPE) <u>Burial</u>		23b. DATE <u>9-7-1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lily Redcreek</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore</u>	
24. FUNERAL DIRECTOR NAME <u>John J. Cowan &amp; Son Inc.</u>		ADDRESS <u>901 Hollers</u>		25a. DATE REC'D BY REGISTRAR <u>SEP - 7 1984</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

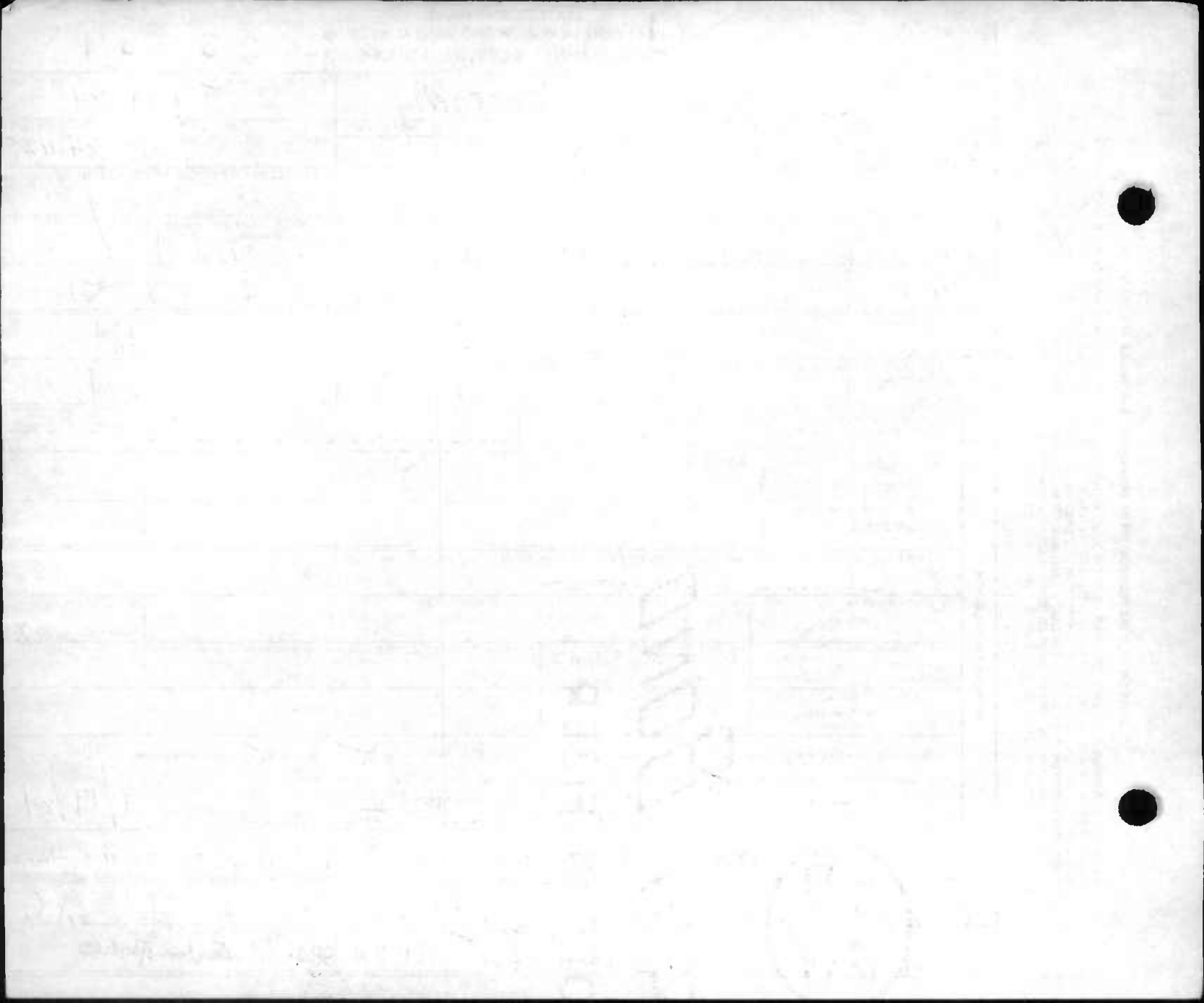
DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23561  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR
ELIZABETH					DUTTON	9 19 84						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Female	Black	3 9 20 64	64 YRS.			9 17 84						1125
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Md.		U.S.A				Balt. County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Dundalk			404 N. Arundale Rd.			Unemployed						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.			Balt.						404 N. Arundale Rd. 2/23			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
John			Kena									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			214-14-8795			Mary Chester			1917 Harlem Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Chronic ischemic myocardial disease</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
<u>Chronic alcoholism</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE			J. Crossan O'Donovan			TITLE (SPECIFY) M.D. Deputy			DATE SIGNED 9/19/84			
EXAMINER'S NAME (TYPE OR PRINT)			J. CROSSAN O'DONOVAN			ADDRESS			2112 Dundalk Ave, Balt., Md. 21222			
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			9-24-84			Crownsville Vet Cem.			Anne Arundel Md.			
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Carlton C. Douglass			669-1738			SEP 24 1984			Alia Davidson-Randall			
ADDRESS			1012 Penn Ave.									





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23562  
REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTABLISHED		2d. HOUR	
JOHN PAUL EDWARDS		9 4 1984		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Male	White	10 16 18	65 YRS.	MONTHS DAYS HOURS MIN	MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
North Carolina		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Dundalk		2814 Yorkway		Electrician	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore		Dundalk	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Samuel Edwards		Bessie Gilredth		213-01-7042	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		17b. INFORMANT		17c. ADDRESS	
Yes WW II		VAMC		Ft. Howard, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) <u>Chronic ischemic myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>7 years</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22b. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		22c. TITLE (SPECIFY)			
ACTUAL SIGNATURE J. Crossan O'Brien		M.D. Deputy		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'BRIEN		ADDRESS 2112 Dundalk Ave., Balb., Md. 21222		DATE SIGNED 9/4/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9/19/1984		Garrison Forest	
24. FUNERAL DIRECTOR NAME		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Duda-Ruck, Inc.		9-21-84			
7922 Wise Avenue Dundalk, MD. 21222					

MEDICAL CERTIFICATION

RECEIVED  
JAN 10 1945

RECEIVED

1945



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

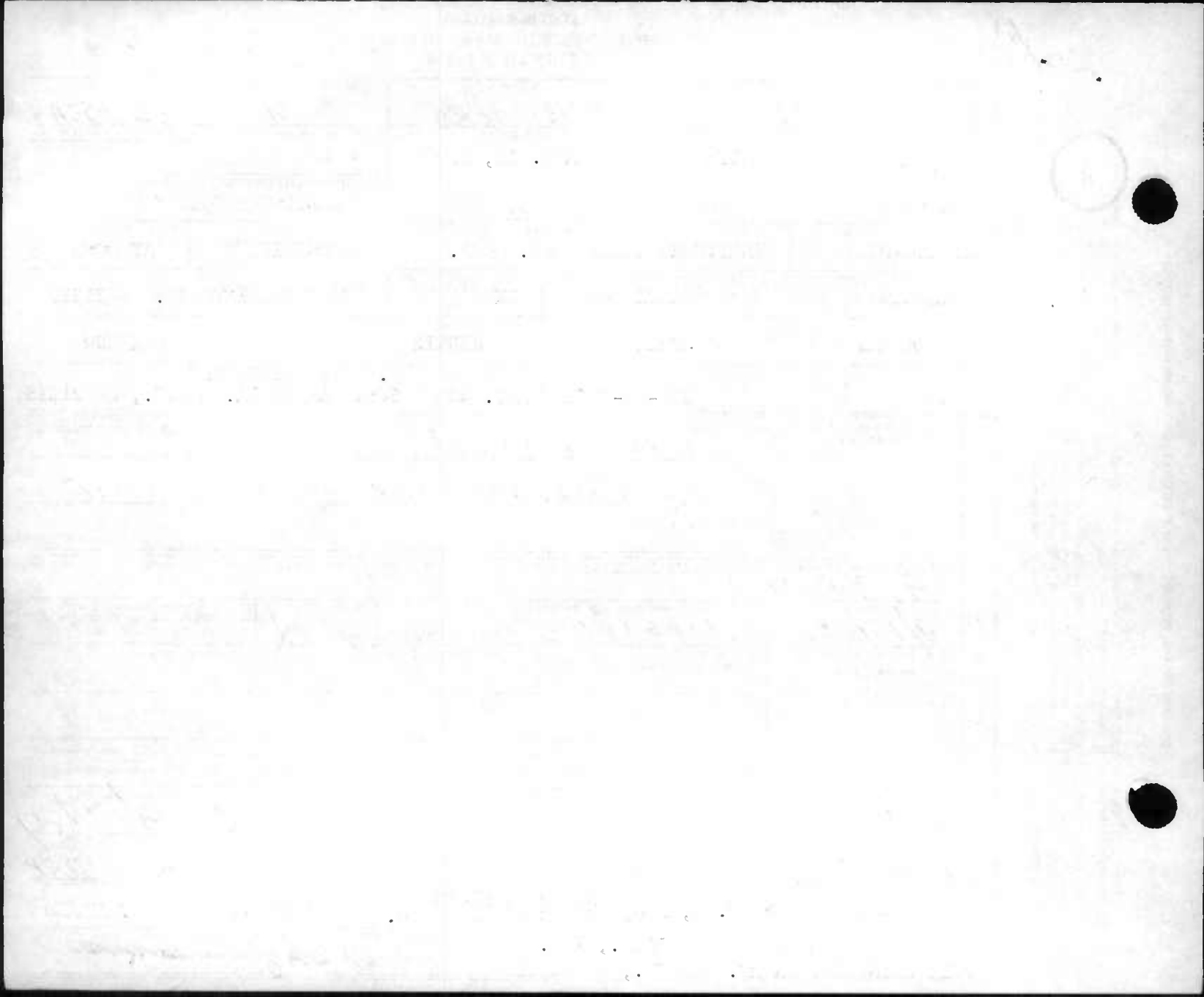
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.				2. DATE OF DEATH		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			3. SEX
FIRST MIDDLE LAST BESSIE EISENBERG			MONTH DAY YEAR 9 16 84			1:53A M			FEMALE
4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS, LAST BIRTHDAY)			7b. CITIZEN OF WHAT COUNTRY?
WHITE			MONTH DAY YEAR APR. 15, 1900			84 YRS.			USA
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH
MARYLAND						BALTIMORE COUNTY			RANDALLSTOWN
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE
BALTIMORE COUNTY GEN. HOSP.			HOUSEWIFE			AT HOME			MARYLAND
13b. COUNTY			13c. STREET ADDRESS / ZIP CODE			13d. INSIDE CITY LIMITS?			14. FATHER'S NAME
BALTIMORE			3606 CLARINTH RD. #21215			YES <input type="checkbox"/> NO <input type="checkbox"/>			SAMUEL
15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT
JENNIE			NO			220-38-8351A			MR. DAVID EISENBERG
UNKNOWN						APT. 428			3601 CLARKS LA. BALTO., MD 21215
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOTENSION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MESENTERIC THROMBOSIS DIFFUSE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.S.C.V.D.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>A.S.C.V.D.</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
9/15/84			INTESTINAL OBSTRUCTION			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Hafeez A. Syed
22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS			22e. DATE SIGNED			22f. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>
HAFAEL SYED			BALTIMORE COUNTY GEN HOSP			9/16/84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR BURIAL PLACE			23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL			SEPT. 17, 1984			MOSES MONTEFIORE WOODMOOR HEBREW CONG.			BALTIMORE COUNTY MARYLAND
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE REC'D. BY REGISTRAR
SOL LEVINSON & BROS., INC.			SEP 19 1984			Julia Davidson			
6010 REISTERSTOWN RD. BALTO., MD 21215									

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
LYNN V. ELLINGER-KERNAN				9/17/84				1:12 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. UNDER 1 YEAR		8. UNDER 24 HRS	
FEMALE	CAU.	MONTH DAY YEAR 01 19 20		64 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MICHIGAN	USA			BALTIMORE COUNTY MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
TOWSON MD	ST JOSEPH HOSPITAL		FACTORY WORKER		WIRE				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD		BALTIMORE		TIMONIUM		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		33 BELFAST RD 21093	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST JAMES		FIRST MIDDLE LAST CARRIE LEWIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		220-16-6059		FAMILY RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) SYSTEMIC ARTERIAL HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 9-16-84 to 9-17 19 84, that (we) lost saw the deceased alive on 9-17 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
JORGE C. SECADA-LOVIO, M.D.						9-17-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JORGE C. SECADA-LOVIO, M.D.		ST. JOSEPH NOSH 7620 YORK RD. TOWSON, MD 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
BURIAL		9-20-1984		DUBOIS VAUX		TIMONIUM BALTO.		MARYLAND	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
EVANS CHAPLO OF CHIMES		2325 YORK ROAD		SEP 24 1984		Julia Davidson			

0110



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2022-2023  
2024-2025



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 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394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Gertrude I. Ellwood								9-20-1984 5:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	White	7 MONTH 12 DAY 1906		78		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Balto. Co.	U. S. A.			Baltimore				MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Glen Arm, Md.	11901 Glenarm Rd.		House wife		Home				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Baltimore		Glen Arm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11901 Glenarm Rd. 21057	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
George Isennock		Ellen Russell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		219-58-2628		Mr. Leo J. Ellwood,		11901 Glenarm Rd.		Glen Arm, Md. 21057	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Congestive Heart Failure								8 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Aortic Stenosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Ventricular Tachycardia/Angina Pectoris									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 6 0

1- FOR  
STATE  
REGISTRAR

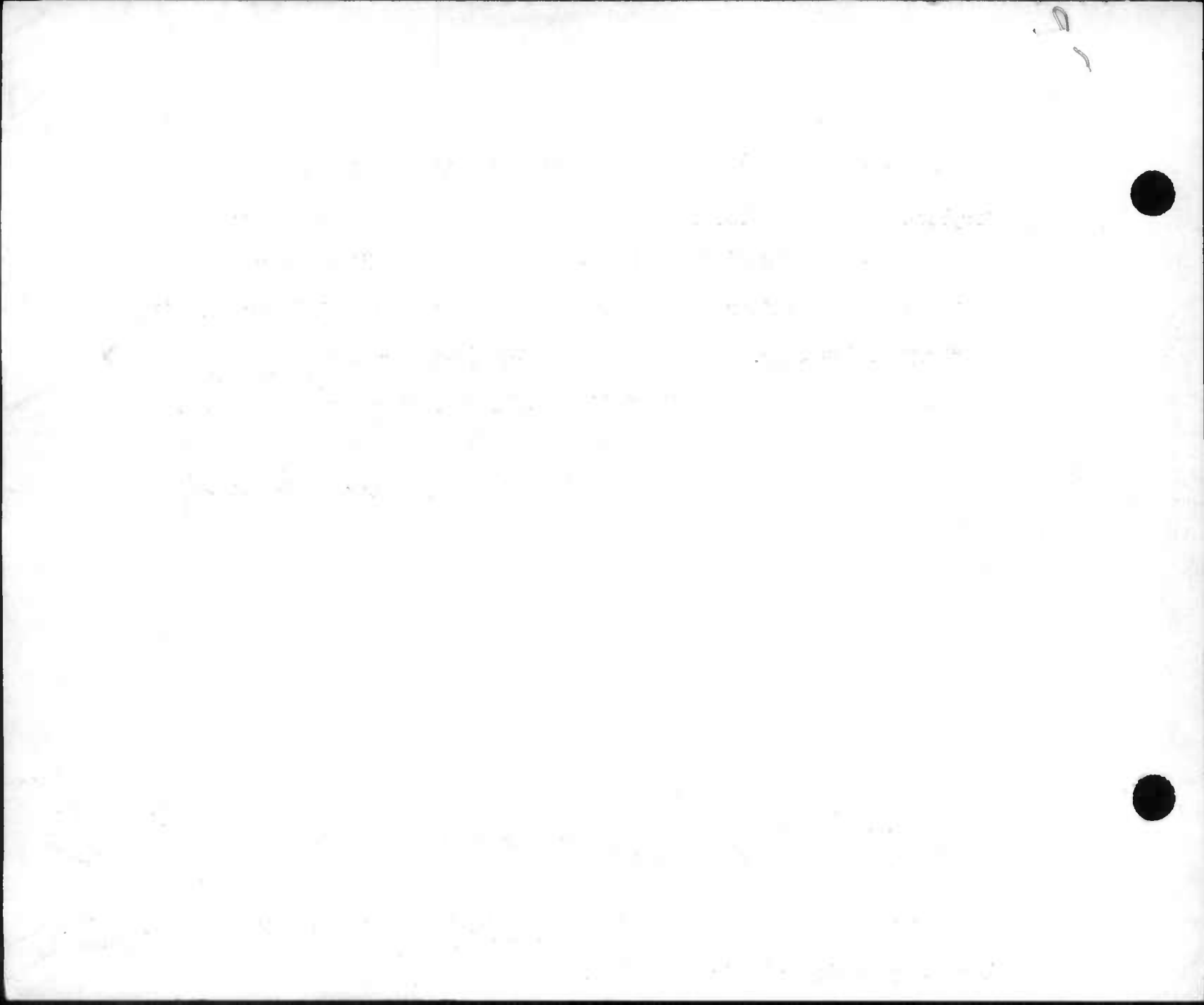
1. DECEASED NAME (TYPE OR PRINT) <b>VIOLET M. ENNIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9-21-84</b>				2b. HOUR <b>6<sup>10</sup> P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 24, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Summitt Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9300 Liberty Rd. 21133</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry D. Caple Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida (nee Gorsuch)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-07-7911</b>		17. INFORMANT ADDRESS <b>Rt. 1, Box 256</b> <b>Roland A. Clark Queenstown, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic meningitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Asx - Libera MMS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>George Angov</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9-27-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE ANGOV</b>				22e. ADDRESS <b>5550 Wilkeson Pk. Bld</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/25/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors Inc. 8728 Liberty Rd. Randallstown 21133</b>				25. DATE REC'D BY REGISTRAR <b>5 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

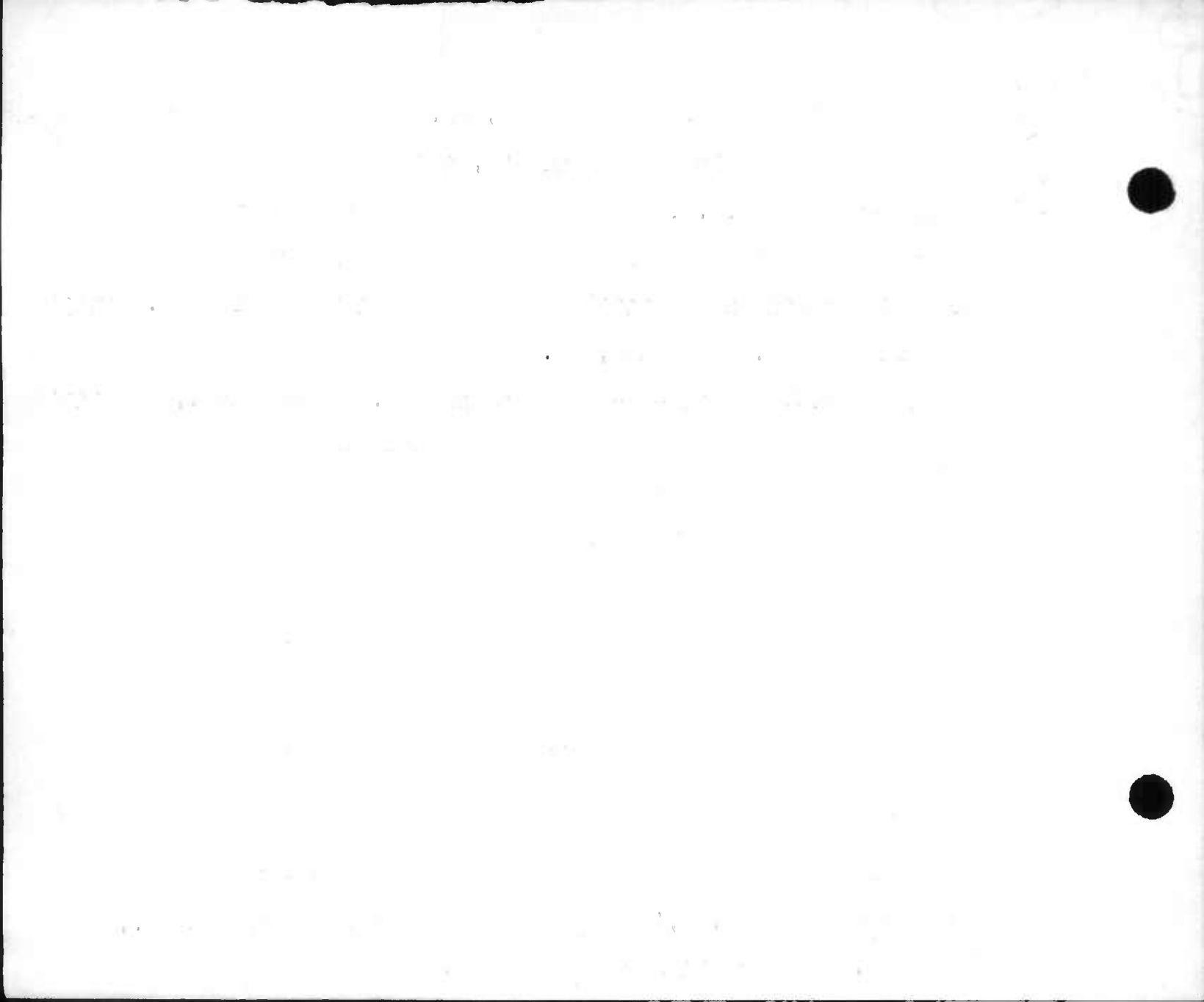
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 23567									
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
CARL W. EUKER, Jr.			09 20 '84			9:20 <sup>A</sup> M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7. IF UNDER 1 YEAR	
Male		White		March 28, 1918		66 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				BALTIMORE COUNTY, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON		GREATER BALTIMORE MEDICAL CENTER			Manager		Rope		
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1824 Deveron Rd. 21234			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Carl W. Euker, Sr.				Gwyndoline Todd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes				W.W. II 218-09-7408		Katharine C. Euker Balto., MD 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b>  DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SEPSIS</b>  DUE TO, OR AS A CONSEQUENCE OF (c) <b>BRAIN TUMOR</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/7 19 84 to 9/20 19 84 that (I) (we) lost saw the deceased alive on 9/20 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David G. Roberts				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
DAVID G. ROBERTS, M.D.				GBMC - 6701 N. CHARLES STREET 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Entombment		Sept. 22, '84		Druid Ridge Cemetery		Baltimore Co., MD			
24. FUNERAL DIRECTOR NAME ADDRESS William E. Johnson 8521 Loch Raven Blvd.									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHW-16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. REG. NO.		3. 4. 5. 6. 8.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Arthur Wilson Fadely</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 30, 1984</b>		2b. HOUR <b>9:40 pm</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 19, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Owings Mills</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>26 Kingsley Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bricklayer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Owings Mills</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>26 Kingsley Road 21117</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Lee Fadely</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie Harmon</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				16b. SOCIAL SECURITY NO. <b>269-12-4901</b>		17. INFORMANT <b>Margaret Fadely</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>4-12</b> , 19 <b>83</b> , to <b>9-30</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9-15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.									
22a. SIGNATURE <b>C E McWilliams</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>10-5-84</b>	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C E McWilliams M.D.</b>						22e. ADDRESS <b>11904 Westlawn Rd. Reston, Va. 20190</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 3, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Carroll Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Eckhardt</b>						25. DATE REC'D. BY REGISTRAR <b>OCT 5 1984</b>			
26. REGISTRAR'S SIGNATURE <b>Eckhardt</b>									

MEDICAL CERTIFICATION

177 Post. 30, 1904 2140 2140

63 June 22, 1917

Belmont County U.S.A.

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Belmont County Belmont County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

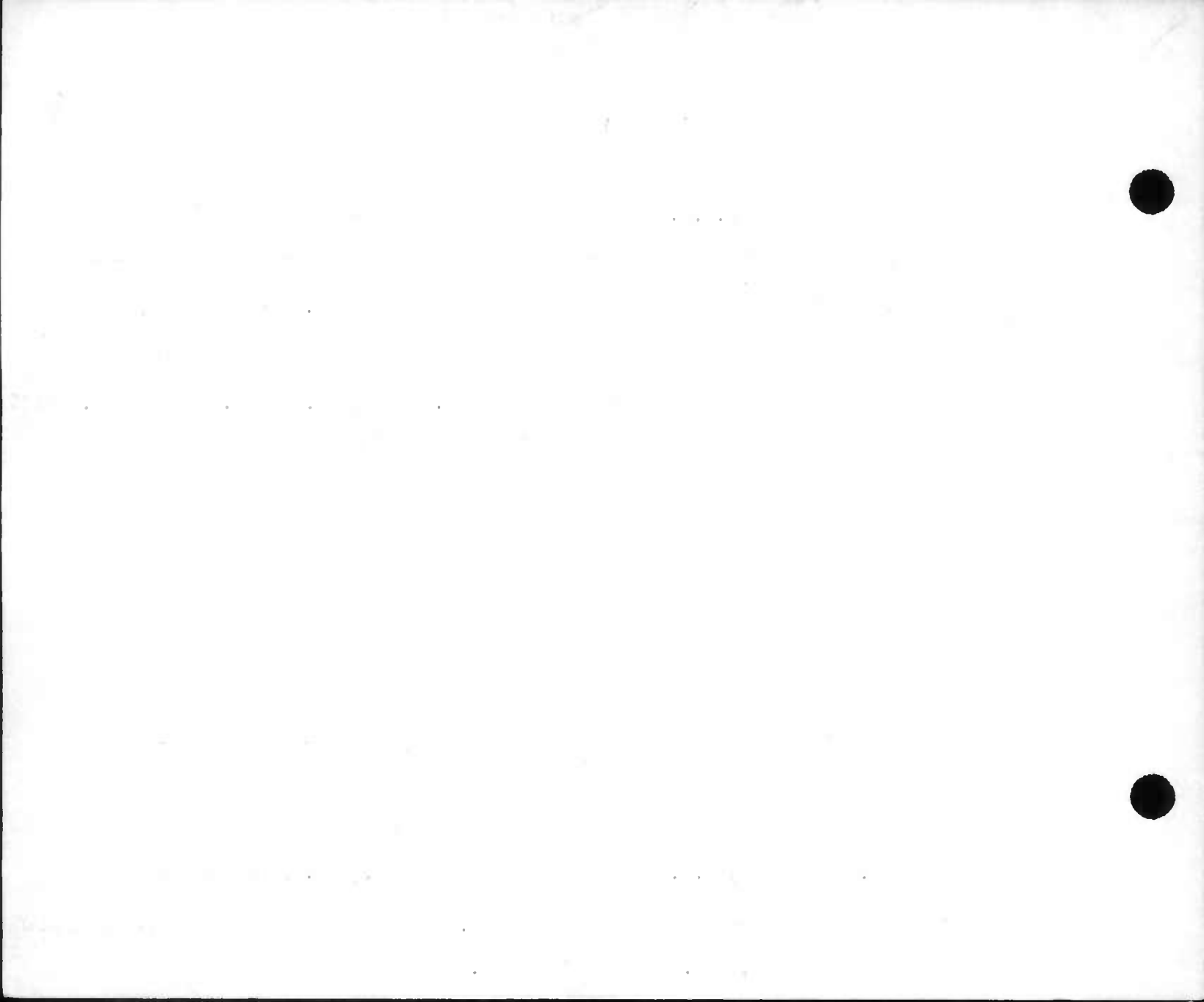
REG. NO.

23569

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LILLIAN M. FAGAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 09 84</b>			2b. HOUR <b>8:15 P.M.</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 16 10</b>		6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>74</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CONNECTICUT</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>622 WARWICK ROAD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>KENSINGTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM MORAVEC</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIE STEVAK</b>		13e. STREET ADDRESS / ZIP CODE <b>622 S. WARWICK ROAD, 21229</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>068-09-1550</b>		17 INFORMANT ADDRESS <b>JAMES E. FAGAN, SR. 622 S. WARWICK RD. 21229</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC BREAST CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> PASSENGER <input type="checkbox"/> ALONE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (b) (the hospital) attended the deceased from <b>10/16</b> 19 <b>82</b> to <b>9/9</b> 19 <b>84</b> that (b) (we) last saw the deceased alive on <b>9/8</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not see the body after death.)							
22a. SIGNATURE <b>Diana H. Griffiths</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/10/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DIANA H. GRIFFITHS, M.D.</b>		22e. ADDRESS <b>ONCOLOGY DEPT., ST. AGNES HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>09-13-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKE VIEW MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SYKESVILLE CARROLL MARYLAND</b>	
24 FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 11 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 7 0

1 - FOR  
STATE  
REGISTRAR

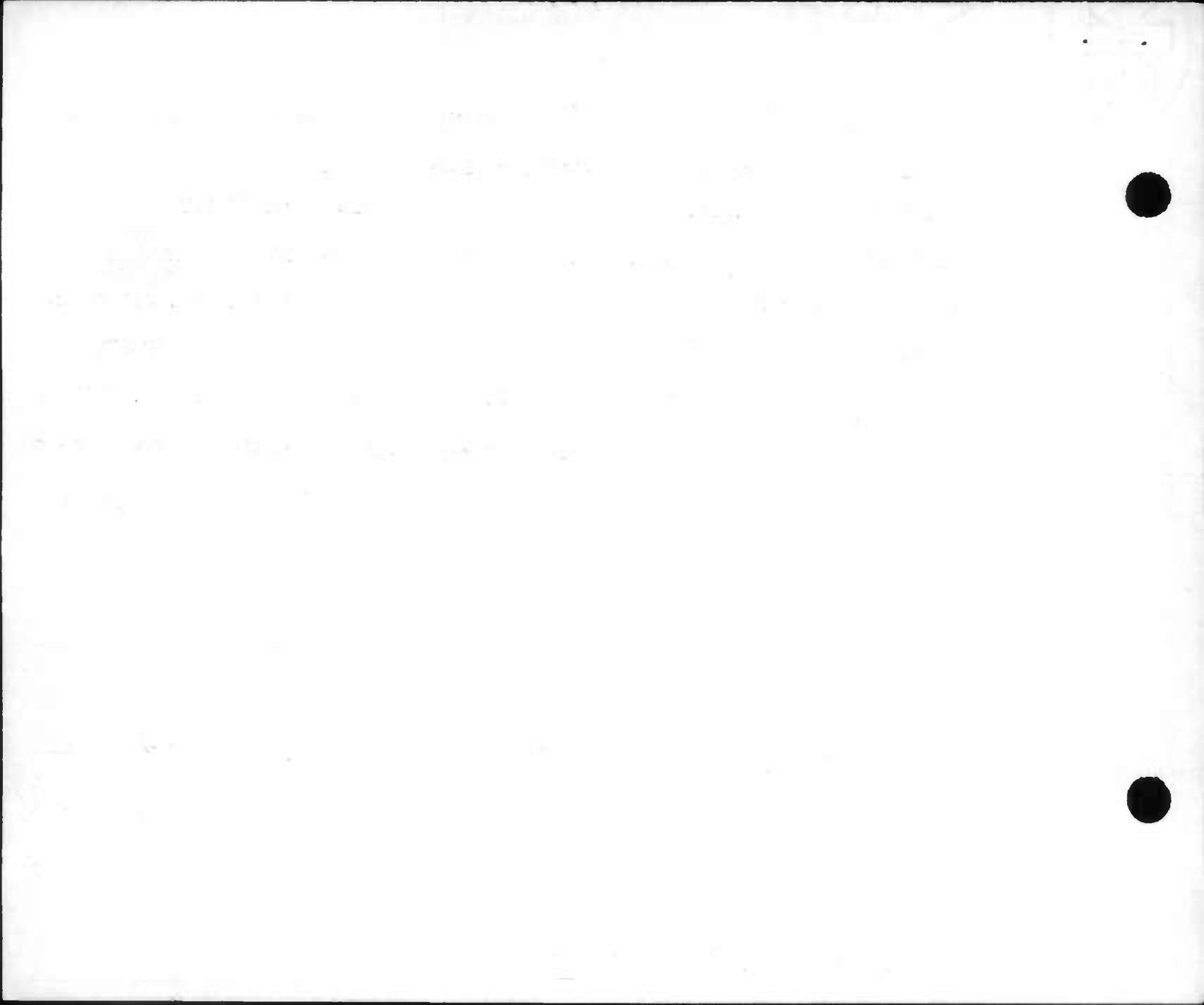
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KAYNE FARBMAN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 1984</b>		2b. HOUR <b>7A.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 26, 1909</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>75</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11 SLADE AVE., APT. 411 (21208)</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>11 SLADE AVE., APT. 411 (21208)</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS MARCUS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LENA LIPSITZ</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-46-3322</b>		17. INFORMANT ADDRESS <b>MRS. BARBARA TAYLOR 2222 CREST RD. (21209)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST. (DOA)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>6 years.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>Aug. 19 1978</b> to <b>Sept 11 1984</b> , that (I) (we) saw the deceased alive on <b>9/31/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Albert J. Himelefars MD</b>				22c. DATE SIGNED <b>9/1/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Albert J. Himelefars FAR 2435 W. Belvedere Ave</b>				22e. ADDRESS <b>21215</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/2/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON CEM</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S NAME <b>SEP 7 1984</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

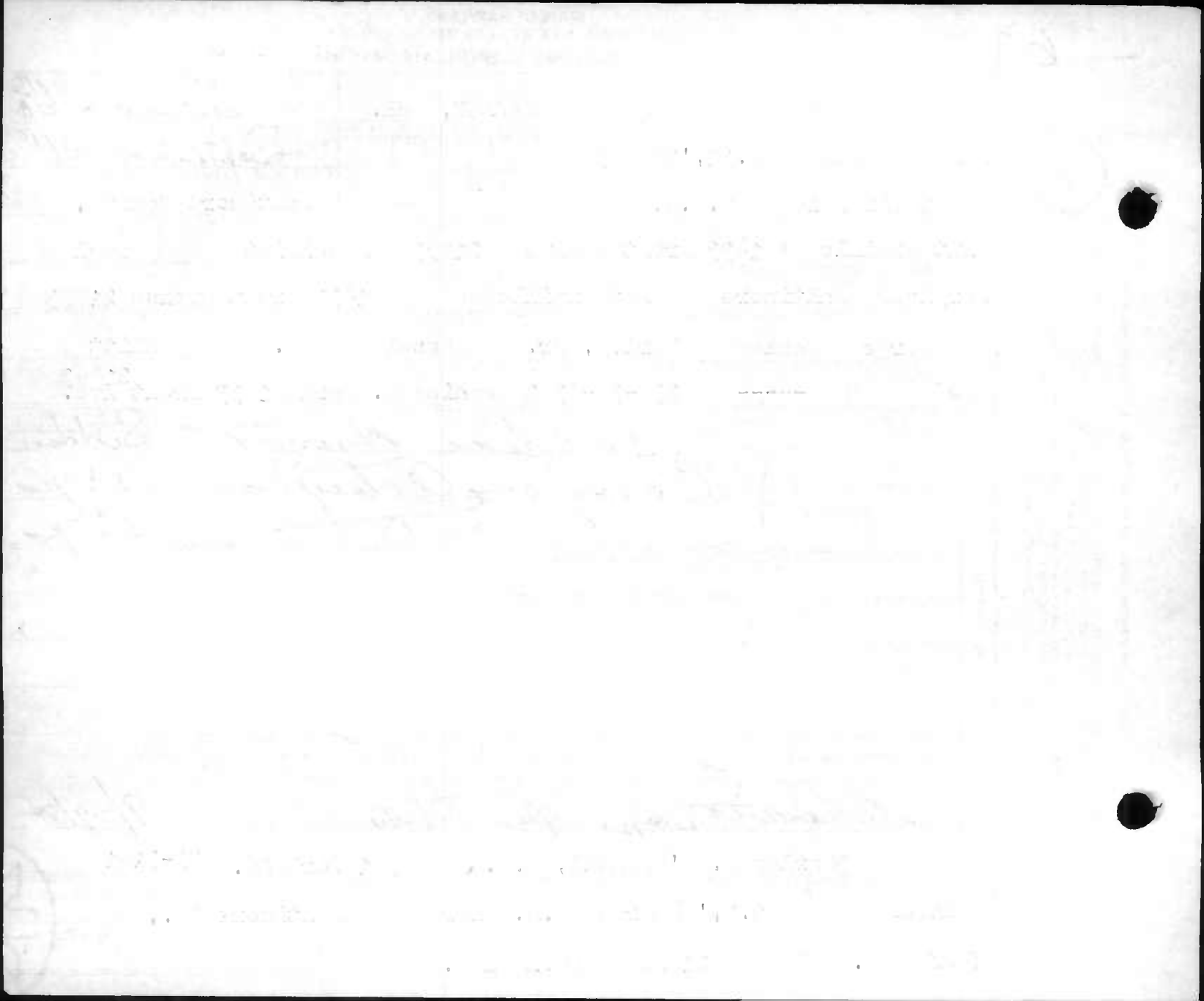
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23571	
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE WESLEY FARLEY, JR.</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>September 29, 1984</b>		2b. HOUR <b>6A</b>		2c. DATE OF DEATH MONTH DAY YEAR <b>September 29, 1984</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 31, '27</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>56</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE OF DEATH MONTH DAY YEAR <b>September 29, 1984</b>		7d. HOUR <b>6A</b>		7e. MINUTE <b>10</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>					
10. CITY OR TOWN OF DEATH <b>Lutherville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1433 Front Avenue 21093</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tool</b>			
13a. STATE <b>Maryland</b>						13b. CITY OR TOWN <b>Baltimore</b>		13c. CITY OR TOWN <b>Lutherville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Wesley Farley, Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hazel H. Whitt</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>236-36-0362</b>		17. INFORMANT ADDRESS <b>Janice G. Farley 21093 1433 Front Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <b>Coronary Artery Disease 5± yrs</b> (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF <b>5± yrs</b> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b>						TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>9/29/84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles F. O'Donnell, M.D.</b>						ADDRESS <b>7501 York Rd. 823-3161</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Oct. 2, '84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace U.M. Church</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD</b>			
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>						ADDRESS <b>8521 Loch Raven Blvd.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

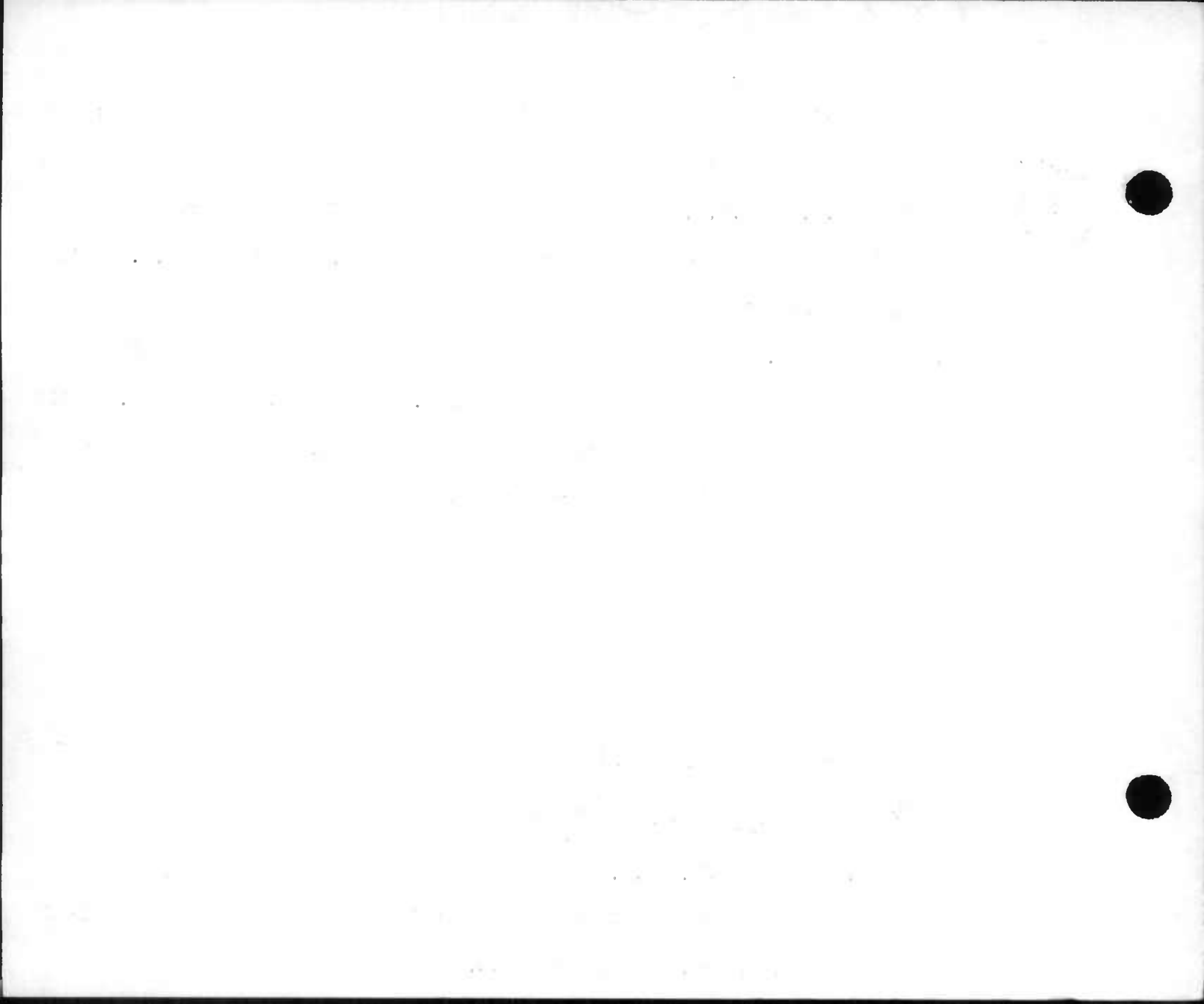
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be attached to this certificate.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 7 2

1. FOR STATE REGISTRAR				2a. DATE OF DEATH				2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)				3 SEX				4. RACE			
FIRST MIDDLE LAST				FEMALE				WHITE			
SUSIE FRANCES FELL				DATE OF BIRTH				75 YRS.			
MONTH DAY YEAR				07 26 09				IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
WASHINGTON, D.C.				U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
CATONSVILLE				INGLENOK NURSING HOME				MED. LIBRARIAN			
12b. KIND OF BUSINESS OR INDUSTRY				13a. STREET ADDRESS / ZIP CODE				13b. COUNTY			
U.S. GOV'T				1235 GREYSTONE ROAD, 21227				BALTIMORE			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
FIRST MIDDLE LAST				FIRST MIDDLE LAST				16b. SOCIAL SECURITY NO.			
JOHN R. ENGLISH				LOTTIE ESTES				214-12-2074			
17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Chronic obstructive pulmonary disease</u> 15 years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
17a. NAME				17b. ADDRESS				17c. DATE			
BERNARD A. FELL				8018 EDGEWATER AVE., 21237				10 years			
19. DATE OF OPERATION				19a. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)				21f. LOCATION			
22a. I certify that (I) <del>XXXX</del> attended the deceased from <u>October 25, 1965</u> to <u>September 24, 1984</u> , that (I) <del>XX</del> last saw the deceased alive on <u>September 11, 1984</u> , and that in (my <del>XX</del> ) opinion death occurred on the date and hour and from the causes stated above; (I) <del>XXXX</del> (did not view the body after death)				22b. SIGNATURE				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				22f. PHYSICIAN'S SIGNATURE			
WILMER K. GALLAGER, JR., M.D.				PINE HEIGHTS & WILKENS AVENUES, 21229				9/25/84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
BURIAL				09-26-84				BALTIMORE NATIONAL			
23d. LOCATION				23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE			
BALTIMORE CITY				SEP 25 1984				a. Wilson-Randall			
24. FUNERAL DIRECTOR				24a. NAME				24b. ADDRESS			
HUBBARD FUNERAL HOME, INC.				4107 WILKENS AVE.				21229			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

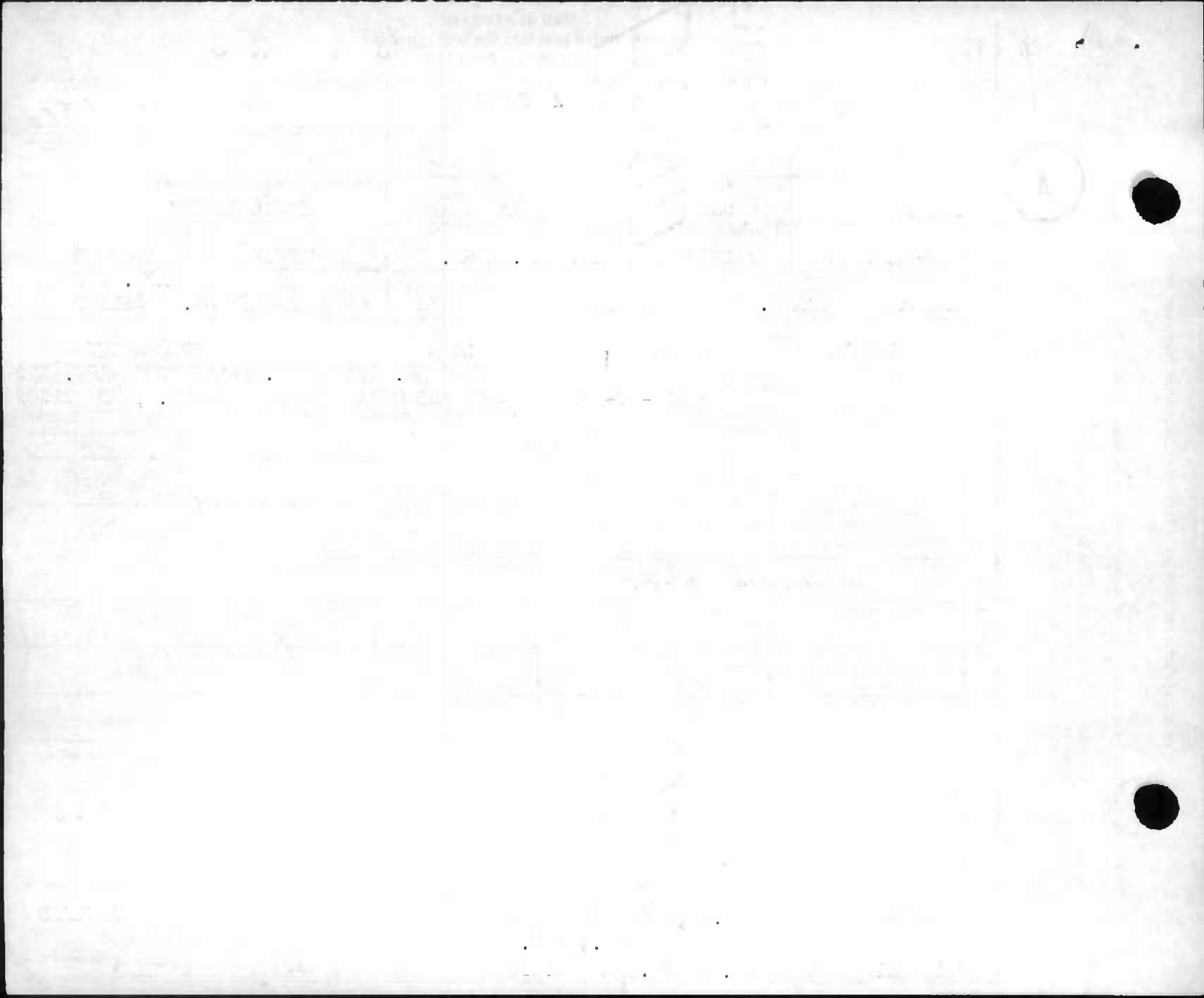
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>MINNIE</i> MIDDLE LAST <i>FELSENBERG</i>			2a. DATE OF DEATH MONTH <i>9</i> DAY <i>11</i> YEAR <i>84</i>		2b. HOUR <i>3:15 PM</i>
3. SEX <i>FEMALE</i>	4. RACE <i>W HITE</i>	5. DATE OF BIRTH MONTH <i>12</i> DAY <i>26</i> YEAR <i>1896</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>87</i> YRS.	# UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE COUNTY</i> MD.	
10. CITY OR TOWN OF DEATH <i>RANDALLSTOWN</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BALTIMORE COUNTY GEN. HOSP.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>BALTO.</i>	13c. CITY OR TOWN <i>BALTIMORE</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <i>ISRAEL</i> MIDDLE LAST <i>BUCKNER</i>			15. MOTHER'S MAIDEN NAME FIRST <i>LENA</i> MIDDLE LAST <i>NEPROTOVSKY</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <i>NO</i> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <i>212-30-3673</i>	17. INFORMANT <i>DR. STANLEY A. FELSENBERG</i> ADDRESS <i>APT. 312 6350 RED CEDAR PLACE BALTO., MD 21209</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Multiple decubiti</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. Boonin, M.D.</i>		DEGREE		22c. DATE SIGNED <i>9/11/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>WISIT BOONIN, M.D.</i>		22e. ADDRESS <i>5635 Old Court Rd.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>SEPT. 13, 1984</i>	23c. NAME OF CEMETERY OR CREMATORY <i>AITZ CHAIM</i>		23d. LOCATION CITY OR TOWN <i>BALTIMORE</i> COUNTY <i>MARYLAND</i> STATE <i>MARYLAND</i>
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON &amp; BROS., INC.</i> ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>			25a. DATE REC'D. BY REGISTRAR <i>SEP 19 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Randall</i>

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		M	
I. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		EVELYN B. FISCHER		09-20-84			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
FEMALE		CAUCASIAN		MONTH DAY YEAR		76		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				BALTIMORE COUNTY		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		ST JOSEPH HOSPITAL		Self Employed		Title Searcher			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD		BALTIMORE		TOWSON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5415 DOWNS / 2100 Road Upperco, Md 509 EAST JOPPA ROAD	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Henry		Anna Evelyn Buettner		NO		212-12-5679		W. Conrad Bishop 5306 Glen Arm Rd 21057	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)	
		CARDIAC ARREST						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		ABSCISSA						1 1/2 hours	
								years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
N/A				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8:45 am 9/20/84 to 10:20 am 9/20/84, that (I) (we) lost									
saw the deceased alive on 9/20/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
James A. Quinlan Jr. MD		MD		9/20/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE RECD. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE			
JAMES A. QUINLAN JR., MD		7801 YORK RD TOWSON, MD 21204				na Davidson-Randall			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE	
Burial		9-24-1984		Loudon Park		Baltimore		Maryland	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ruck Towson Funeral Home, Inc.		Towson, Maryland		1050 York Road		SEP 24 1984			

BP

62-50-20

EXHIBIT

EVERY

01 - 20 - 08

CAUCASIAN

REMAINS

BALTIMORE COUNTY

X

ST JOSEPH HOSPITAL

TOWSON

X 500 EAST WOODWARD

BALTIMORE TOWSON

STAY

STAYED IN ROOM 101

RAY

RECEIVED

2008 5 4 14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

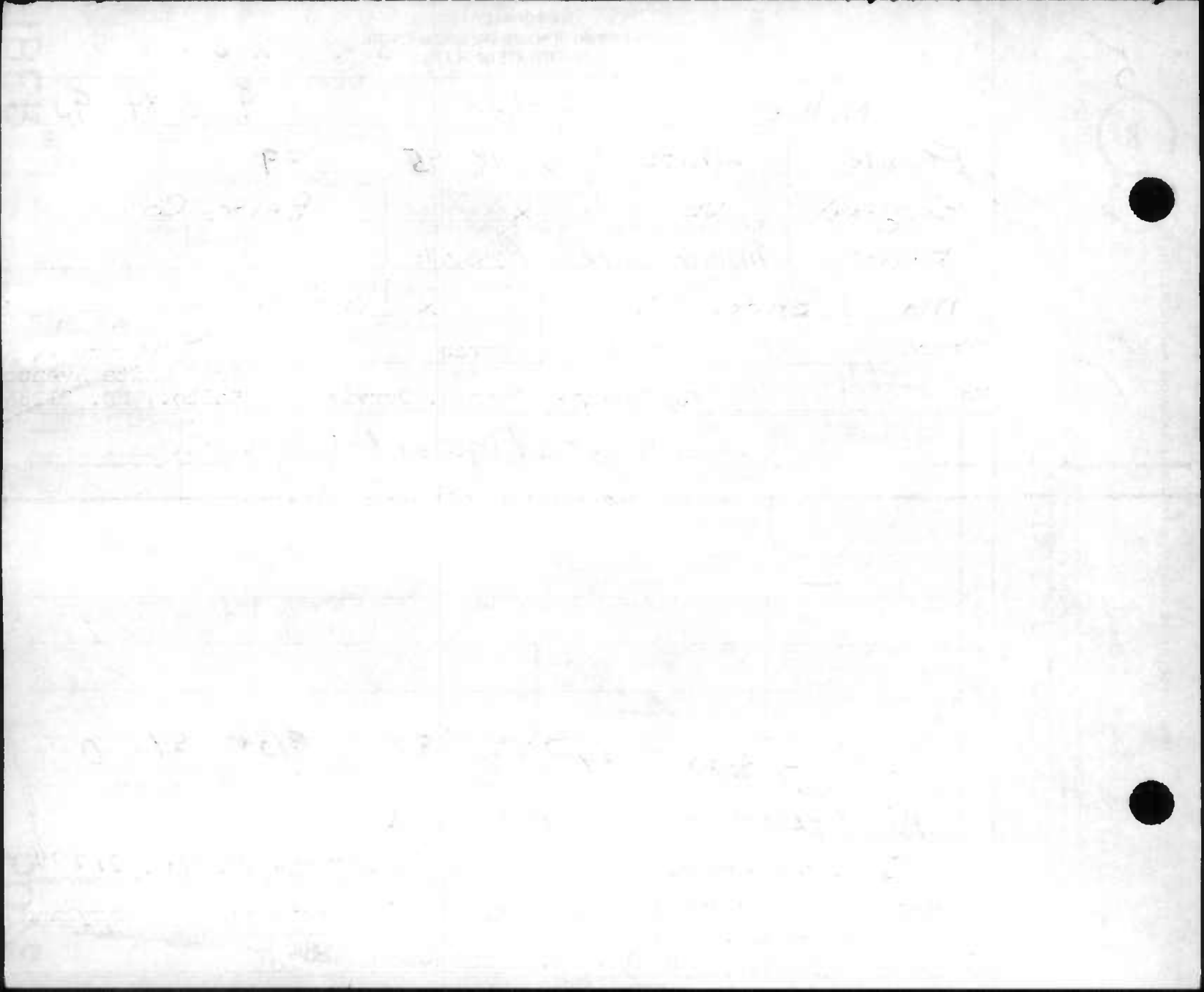
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Nellie Fisher</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 3 84</b>		2b. HOUR <b>9p</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 18 95</b>		6. AGE (IN YEARS, LAST BIRTHDAY) YRS <b>89</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Rossville</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13a. STATE <b>md.</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Rosedale</b>	13e. STREET ADDRESS / ZIP CODE <b>6600 Ridge Road 21237</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Horton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Wootton</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-74-8638</b>		17. INFORMANT ADDRESS <b>Joan A. Purvis 3910 White Avenue Balto., MD. 21206</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>8/22</b> 19 <b>80</b> , to <b>9/30</b> 19 <b>84</b> , that (2) (we) lost above (1) (we) (did not) view the body after death. <b>24</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <b>A. Haroun</b>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. HAROUN</b>		22e. ADDRESS <b>108 S. Taylor Ave, Balto. 21221</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9/6/1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1984</b>		
			25b. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>		

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 3 5 7 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

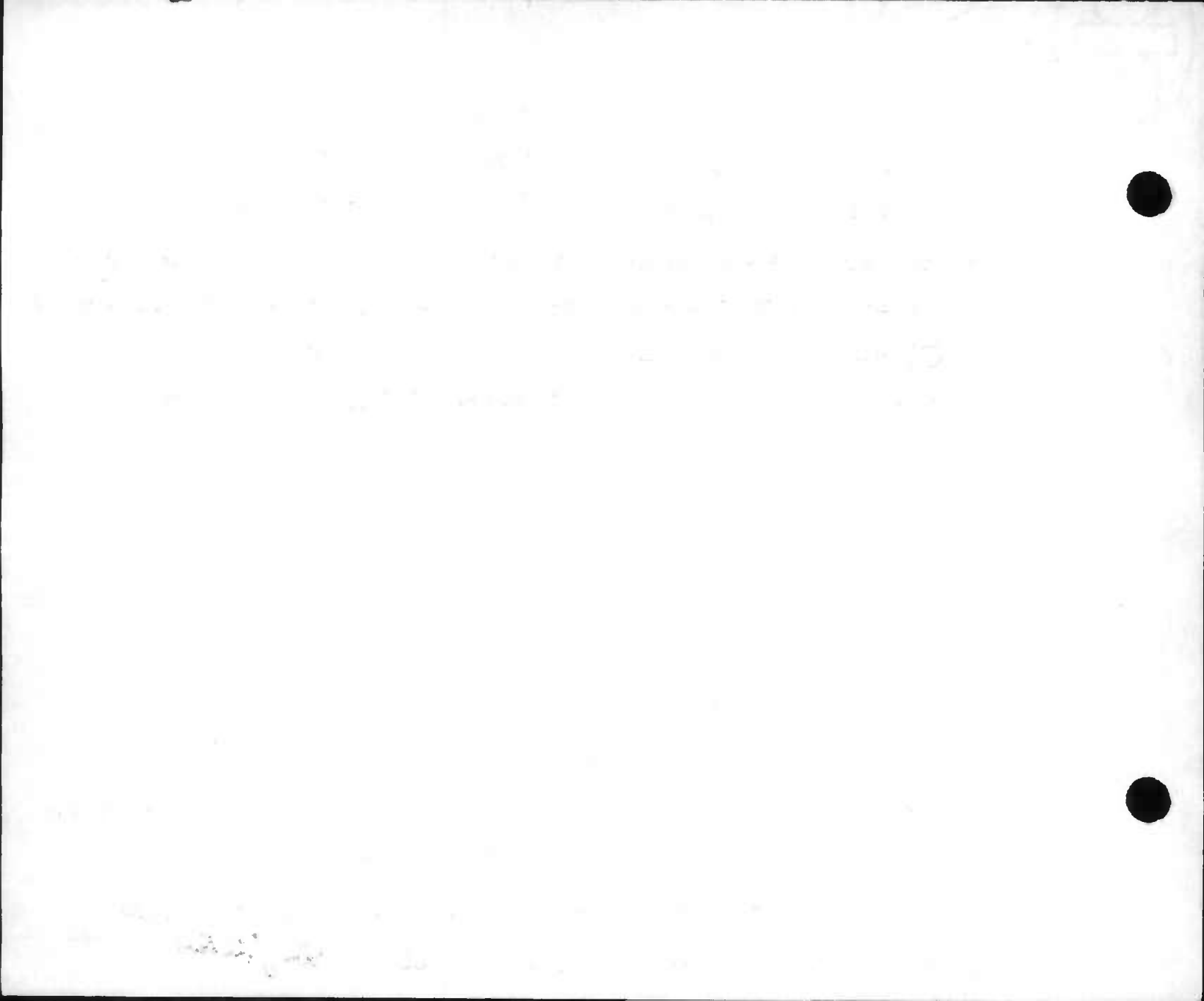
1 DECEASED NAME (TYPE OR PRINT) Henry M. FITZ, Sr			2a. DATE OF DEATH MONTH DAY YEAR September 13, 1984			2b. HOUR 9:25 P.M.			
3 SEX M		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1/15/14		6 AGE (IN YEARS LAST BIRTHDAY) 70		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AIRCRAFT		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN WHITE MARSH		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6013 LORELEY BEACH RD 21162	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN FITZ			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 09 1748		17 INFORMANT ELLEN FITZ		ADDRESS ABOVE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from AUG. 13, 1976, to SEPT. 13, 1984, that (I) (we) lost saw the deceased alive on AUG. 7, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. J. PAGLINAWAN, MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-17-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T-J. PAGLINAWAN, MD				22e. ADDRESS 8557 PHILA. RD. 20237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/17/84		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD			
24 FUNERAL DIRECTOR NAME J.E. CORNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR SEP 18 1984			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 4/83  
(VRA 15, 4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond H. FOWLER			2a. DATE OF DEATH MONTH DAY YEAR September 5 1984			2b. HOUR 10:12 <sup>AM</sup>			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 9 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY State of Md.	
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 12 Belhaven Dr. Balto., Md. 21236		
14. FATHER'S NAME FIRST MIDDLE LAST Joshua H. Fowler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda L. Hughes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 215-07-3336		17. INFORMANT ADDRESS Hazel L. Fowler 12 Belhaven Dr. 21236				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Lung Cancer</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>August 19, 1984</u> , to <u>September 5, 1984</u> , that (I) (we) last saw the deceased alive and above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Naem Gauhar</i>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NAEM GAUCHAR				22e. ADDRESS 5400 Old Ct. Road, BALTO, MD 21133					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-8-1984		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Lassahn FH 7401 Belair Rd				25a. DATE REC'D. BY REGISTRAR SEP 11 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>			

MEDICAL CERTIFICATION

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1. *Introduction*

0553-10-CA

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

STANDARD INDEX

2005-06-01



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 7 8

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Walter Oliver FROYD		September 12, 1984		7:58 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		7-28-1907		77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		U.S.A.				Baltimore County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rossville		Franklin Square Hospital		Door Man		Gardenville	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
John H. Froyd		Emily		No		211-09-5063	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Mrs. Joan L. Kaminski		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
ADDRESS		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
508 S.W. Buswell Ave. Port St. Lucie, Fla.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR P.M. 19				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. INJURY OCCURRED		21g. LOCATION		21h. LOCATION		21i. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		CITY OR TOWN STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from August 25, 19 84, to September 12, 19 84, that (we) last saw the deceased alive on September 12, 19 84, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
		Faith Q. English MD		9/12/84		Dr. Keith Q. English, MD	
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS	
		9000 Franklin Square Drive, 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN, COUNTY, STATE)	
Burial		9-15-84		Gardens of Faith Cem.		Balto. Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
John C. Miller Inc-6415 Belair Rd.-21206		SEP 13 1984		C. Davidson			

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John H. Ford

John H. Ford

21-1-1975  
John H. Ford  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23579	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles M. Gail</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9 14 84</b>	
3. SEX <b>male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 26 91</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>93</b> YRS.	
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Rossville</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Martin-Marietta Co.</b>			
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>BALTIMORE</b>		13c. STREET ADDRESS / ZIP CODE <b>4634 Bowleys Lane 21206</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Gail</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katie Bauch</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-07-5487A</b>		17. INFORMANT ADDRESS <b>Mrs. Hannah L. Gail 4634 Bowleys Lane 21206</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>OLD AGE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HISTORY OF STROKE AND HEART ATTACK</b>					
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) _____	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____	
22a. I certify that (I) (the hospital) attended the deceased from <b>9-6-84</b> 19 <b>84</b> , to <b>SEPT 14</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive <b>9-6-84</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Kate Tully MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-14-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KATE TULLY MD</b>		22e. ADDRESS <b>626 TOWNE CENTRE DR. JOPPA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-18-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Lassahn Funeral Home 7401 Belair Rd. BALTO. MD. 21236</b>					

BP

*(continued)*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 8 0

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST: HERMAN MIDDLE: J. LAST: GANZER			2a. DATE OF DEATH MONTH: 9 DAY: 30 YEAR: 1984		2b. HOUR 6:15 AM
3. SEX MALE	4. RACE CAU	5. DATE OF BIRTH MONTH: 8 DAY: 27 YEAR: 1899	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS: _____ DAYS: _____	IF UNDER 24 HRS. HOURS: _____ MIN: _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11 Deneison St. 21093	
14. FATHER'S NAME FIRST: George MIDDLE: Ganzer LAST: _____		15. MOTHER'S MAIDEN NAME FIRST: Babbette MIDDLE: _____ LAST: _____		ADDRESS: 11 Deneison St. Timonium, Md. - 21093	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-12-4003		17. INFORMANT Mrs. Maria E. Ganzer	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION 9/15/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED AORTIC ANEURYSM		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET: _____ CITY OR TOWN: _____ COUNTY: _____ STATE: _____	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/15/84</u> 19 <u>84</u> , to <u>9/30</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>above</u> , (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Uberoi		DEGREE		22c. DATE SIGNED 9/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. UBEROI		22e. ADDRESS 6701 N. CHARLES STREET-GBMC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 10-2-84	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION CITY OR TOWN: Balto. MD. COUNTY: _____ STATE: _____		
24. FUNERAL DIRECTOR NAME: John C. Miller Inc. - 6415 Belair Rd. - 21206 ADDRESS: _____			25a. DATE REC'D. BY REGISTRAR: OCT 2 1984		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

must be notified at once

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

12541

BALTIMORE COUNTY

U.S.A.

General

Tolson

CHARLES STREET Cabinet Maker

11 Darnon St. x 21093

Balto. Timonium

11

Robbette

General

11 Darnon St.

Timonium 44-21093

W.A. Loria 3. Surge

217-12-4003

11

RECEIVED 11-1-54

11

Remotion 10-2-R Government Cemetery - Balto. 11.

John C. Miller Inc. - 217 Darnon St. - 21093

#1, FilmG596 10/8/84 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 8 1

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST Helyn Jeanne Becker Gentile		Female		White	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
New York		USA			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Timonium		240 E. Padonia Rd., 21093		Teacher	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore		Timonium	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Elmer Daniel Dinkelacker		Marie Knoblock		No -	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
279-30-1302		Suzanne M. Chavis, 240 E. Padonia Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ischaemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11</u> 19 <u>81</u> to <u>9/30</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE <u>Davis M. Hahn</u>		DEGREE <u>MD</u>		27c. DATE SIGNED	
27d. PHYSICIAN'S NAME (TYPE OR PRINT)		27e. ADDRESS			
Davis Hahn M.D.		Good Samaritan Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		10/1/84		Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION CITY OR TOWN COUNTY STATE	
Catonsville Balto. Md.		Westview Crematory		Catonsville Balto. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Martin D. Lawson, 10 W. Padonia Rd.		OCT 3 1984		<u>M. Davidson</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMAL PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 3 5 8 2  
REG. NO.

1- FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH										2b. DATE KNOWN OF DEATH										2d. HOUR																													
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2. DATE KNOWN OF DEATH										2b. DATE KNOWN OF DEATH										2d. HOUR																			
WILLIAM T. GERRINGER																				September 19, 1984										11 PM																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. IF UNDER 1 YR.										8. IF UNDER 24 HRS.									
male										black										4 11 23										61 YRS.																													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. NEVER MARRIED										10. BALTIMORE CITY OR COUNTY OF DEATH																			
N. Carolina										U.S.A.										WIDOWED										DIVORCED										Baltimore County, MD.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																													
Towson										Greater Baltimore Medical Ctr.																																																	
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																			
Maryland																				Baltimore										YES NO										2810 Rockrose Avenue 21215																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16. WAS DECEASED EVER IN U.S. ARMED FORCES?										17. SOCIAL SECURITY NO.										18. INFORMANT																			
Boyd										Gerringer										Martha										NO										238-24-6880										Lois Gerringer 2810 Rockrose Ave.									
19. WAS DECEASED EVER IN U.S. ARMED FORCES?										20. SOCIAL SECURITY NO.										21. INFORMANT										22. ADDRESS										23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
NO										238-24-6880										Lois Gerringer										2810 Rockrose Ave.										Sudden																			
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										25. PART I DEATH WAS CAUSED BY:										26. IMMEDIATE CAUSE (a)										27. DUE TO, OR AS A CONSEQUENCE OF										28. (b)																			
																				Cardiac Arrest										ASCD										2+ yrs																			
29. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										30. DEATH RESULTED FROM:										31. Autopsy										32. Inspection										33. Inquiry																			
										Natural cause																																																	
34. DATE OF OPERATION										35. CONDITION FOR WHICH OPERATION WAS PERFORMED?										36. AUTOPSY?										37. YES										38. NO																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										YES										NO																			
21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										22. UNDERLYING										23. OR																			
CONTRIBUTING										P.M.										19																																							
24. INJURY OCCURRED										24a. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										24b. LOCATION										25. CITY OR TOWN										26. COUNTY																			
WHILE										STREET, FACTORY, FARM, ETC.)										STREET										CITY OR TOWN										COUNTY																			
AT WORK										STREET, FACTORY, FARM, ETC.)										STREET										CITY OR TOWN										COUNTY																			
27. I certify that I took charge of the remains described above, held an										28. Autopsy										29. Inspection										30. Inquiry										31. and in my opinion																			
death resulted from:										Natural cause										Accident										Suicide										Homicide										Undetermined manner									
32. ACTUAL SIGNATURE										33. TITLE (SPECIFY)										34. MEDICAL EXAMINER										35. DATE SIGNED										36. 9/25/84																			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS										37. BURIAL										38. DATE										39. NAME OF CEMETERY OR CREMATORY										40. LOCATION									
																				9/26/84										Cedar Hill Cemetery										Anne Arundel Co., Md.																			
41. FUNERAL DIRECTOR										42. DATE REC'D. BY REGISTRAR										43. REGISTRAR'S SIGNATURE										44. Wm C March F/H Inc. 1101 E North Avenue										SEP 26 1984																			
NAME										ADDRESS										45. DATE REC'D. BY REGISTRAR										46. REGISTRAR'S SIGNATURE										47. Wm C March F/H Inc. 1101 E North Avenue										SEP 26 1984									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

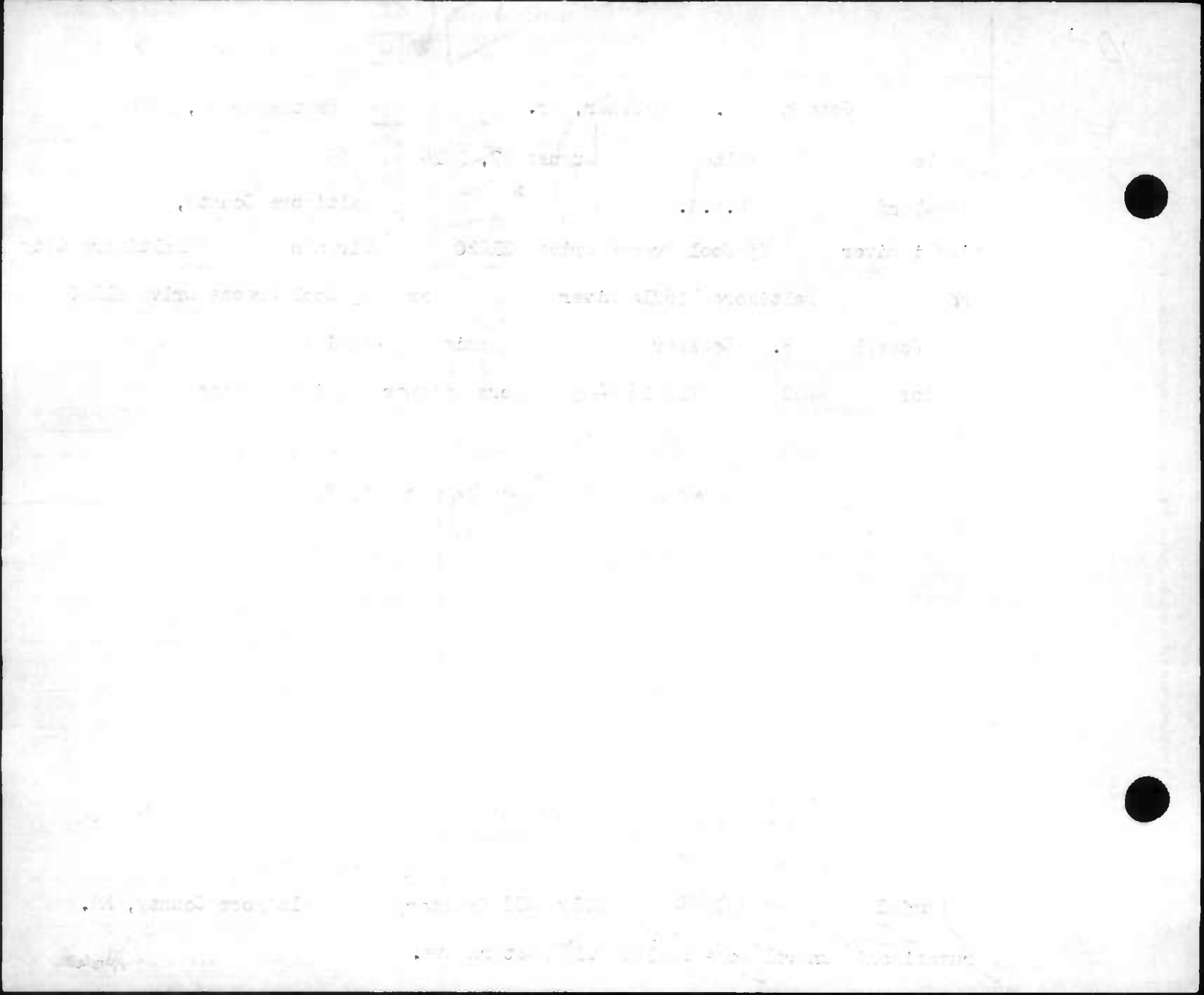
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the coroner.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		2 3 5 8 3	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Joseph F. Gessner, Sr.		September 28, 1984		M	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		August 27, 1914	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.			
9. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Middle River		25 Cool Breeze Drive 21220		Firemen	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md		Baltimore		Middle River	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS	
Joseph F. Gessner		Annie Jenkins		25 Cool Breeze Drive 21220	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WWII 212 16 4495		Nora Gessner (Wife) Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Melastatic Renal cell carcinoma			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b)			
		Respiratory Failure 2° to #1			
		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
S. Milner		M.D.		9/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
S. Milner		5400 Old Court Rd			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10/2/84		Holly Hill Cemetery	
23d. BURIAL DIRECTOR		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.		OCT 1 1984		J. Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Harold Getty			2a. DATE OF DEATH MONTH DAY YEAR 9 6 1984			2b. HOUR 3:45 P <sub>M</sub>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 26 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, County MD.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Jenkins Memorial Home 1000 S. Caton Avenue 21229		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Hotel	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1215 N. Calvert St. 21202							
14. FATHER'S NAME FIRST MIDDLE LAST John Frederick Getty		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Copeland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWI		16b. SOCIAL SECURITY NO. 214--05-0875		17. INFORMANT ADDRESS Mrs. D.A. Sattler 824 Corbett Road 21111			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mastatic C.A.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.O.L.S.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-17-82</u> 19 <u>82</u> , to <u>9-6-84</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>9-6-84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>George Angol</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-7-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE ANGOL		22e. ADDRESS 5550 Wilkens Dr. - Bal					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-8-84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Road 221212				25a. DATE REC'D. BY REGISTRAR SEP 10 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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## REFERENCES

1991-1992

1-2000

100-1-6

	1999-2000	2000-2001
1. <i>Chrysomelids</i>	10	10
2. <i>Curculionids</i>	10	10
3. <i>Chrysomelids</i>	10	10
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91. <i>Chrysomelids</i>	10	10
92. <i>Chrysomelids</i>	10	10
93. <i>Chrysomelids</i>	10	10
94. <i>Chrysomelids</i>	10	10
95. <i>Chrysomelids</i>	10	10
96. <i>Chrysomelids</i>	10	10
97. <i>Chrysomelids</i>		

1.  $\frac{1}{2}$  (1990)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

UNKNOWN #84-73

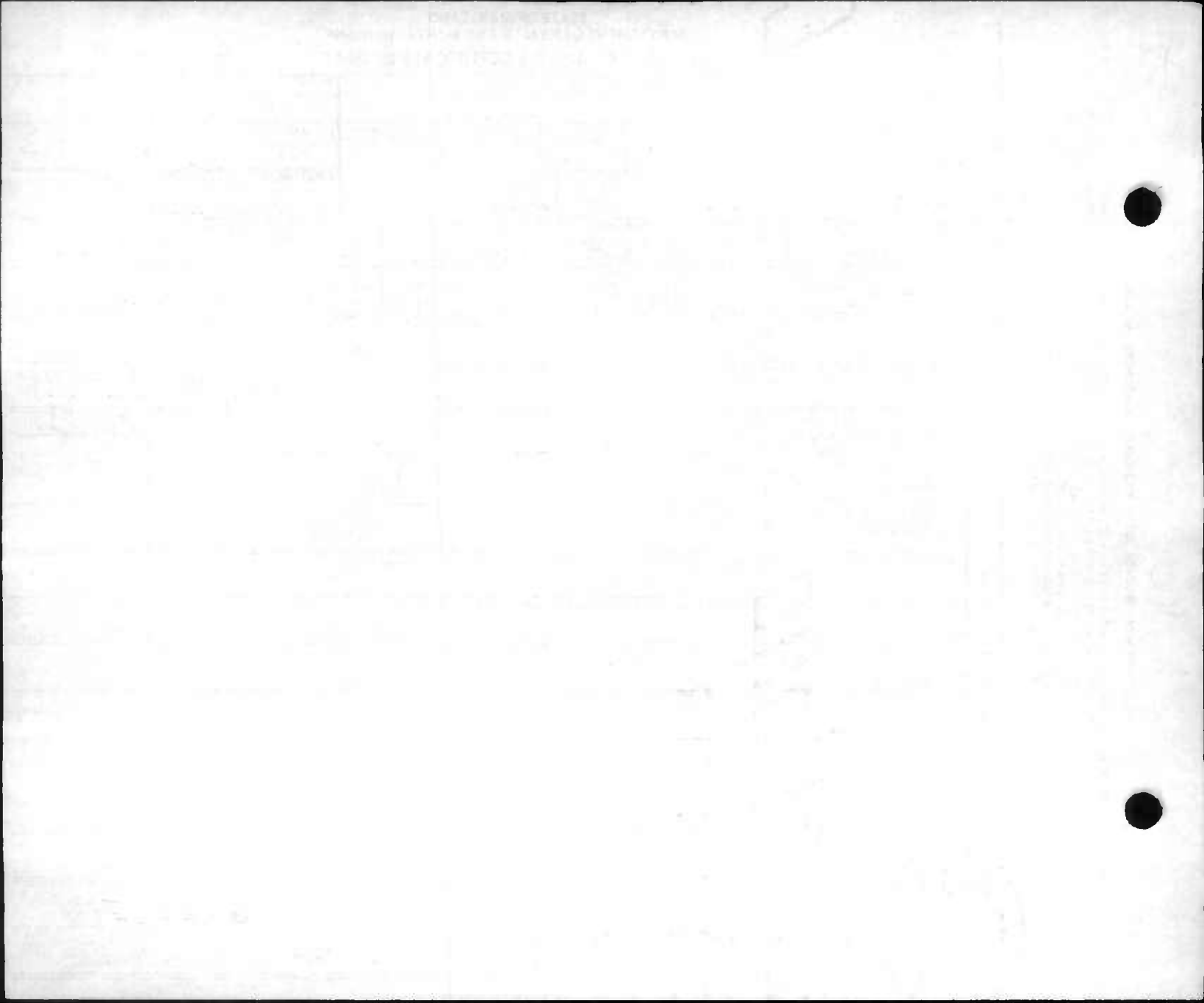
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 3 5 8 5  
REG. NO.

1- STATE REGISTRAR		FOR UNKNOWN #84-73		2 3 5 8 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH	
ALEXANDER				DATE KNOWN OF DEATH MATED 9 14 19 84	
2. SEX				2b. DATE PRONOUNCED DEAD	
Male				DATE PRONOUNCED DEAD 9 16 19 84 7:45 P M	
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
White		2 18 42		42 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	
Romania		U.S.		NEVER MARRIED	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cockeysville		Wooded area I-83 at Padonia Rd.		Teacher	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
DIST. COLUMBIA		Washington		St. Eliz. Hosp. 20032	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		12b. KIND OF BUSINESS OR INDUSTRY	
Otto		Ghebhardt		Science	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No				Mrs. Alexandrina Svoronov Wash., D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		M.D. Assistant		9-17-84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Removal		9/26/84		23d. LOCATION CITY OR TOWN	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
WOODLAWN MEMORIAL F.H. Anatomy Board		Balto., Md.		25b. REGISTRAR'S SIGNATURE	
				GUECE Julia Davidson-Randall	

BP

DHMH - 17  
(VR A15 ME 15)  
20M A 82





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23586	
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES DANIEL GIBSON</b>						2a. DATE KNOWN OF DEATH MONTH <b>XX</b> DAY <b>9</b> YEAR <b>84</b>		2b. HOUR M <b>10:40</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>30</b> YEAR <b>1951</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>32</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD MONTH <b>9</b> DAY <b>8</b> YEAR <b>84</b>		2d. HOUR am <b>10:40</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodlawn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3526 St. James Rd. 21207</b>			
4. FATHER'S NAME FIRST <b>Robert H.</b> MIDDLE <b>Gibson</b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Charlotte</b> MIDDLE <b>Cornwell</b> LAST <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-54-6562</b>		17. INFORMANT <b>735 Clifffedge Robert H. Gibson Balto., Md. 21208</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8880</b> IMMEDIATE CAUSE (a) <b>Subdural hematoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>6:30</b> AM <b>PM</b> MONTH <b>9</b> DAY <b>1</b> YEAR <b>84</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) <b>subject apparently fell striking head</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>			21f. LOCATION STREET <b>?</b> CITY OR TOWN <b>Baltimore Co., Md.</b> COUNTY <b></b> STATE <b></b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>			TITLE (SPECIFY) <b>Assistant</b>						DATE SIGNED <b>9-9-84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn Street</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Sept. 11, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>			23d. LOCATION CITY OR TOWN <b>Baltimore City, Md.</b> COUNTY <b></b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md.</b> ADDRESS <b>6500 York Rd. 21212</b>						25. DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

520-24-6263

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23581

1- FOR  
STATE  
REGISTRAR

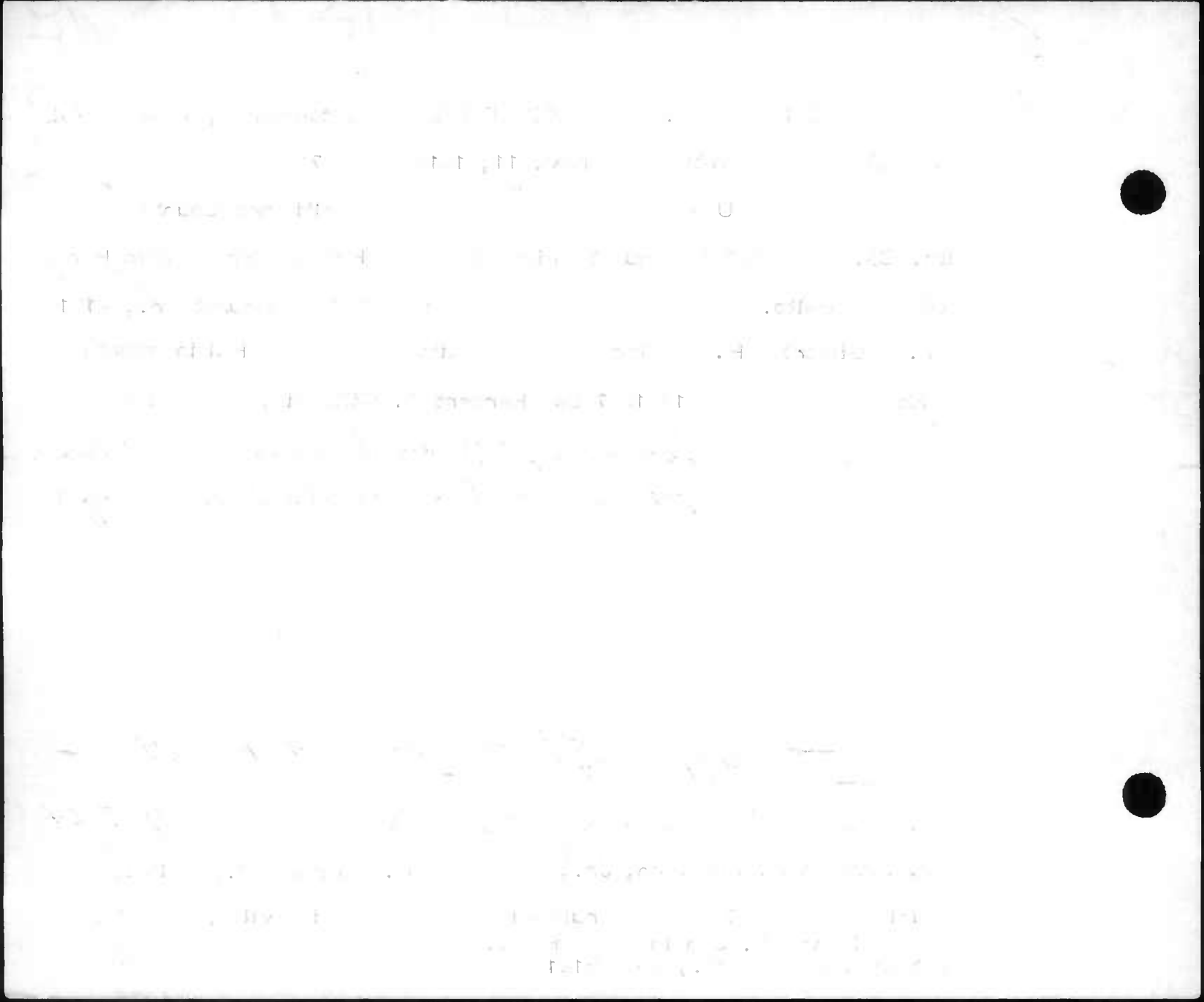
1. DECEASED NAME (TYPE OR PRINT) EDITH A. GILLESPIE			2a. DATE OF DEATH MONTH DAY YEAR September 4, 1984		2b. HOUR 4 AM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10 CITY OR TOWN OF DEATH Balto. Co.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6003 Lakehurst Drive #3		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY Balto.	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6003 Lakehurst Dr., 21210
14. FATHER'S NAME FIRST MIDDLE LAST Dr. Gilbert H. Alford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Hallingsworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 18 7054	17. INFORMANT ADDRESS Herbert B. Gillespie, Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A-S Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>did not</u> attend the deceased from above, (I) <u>did</u> (I) <u>did not</u> view the body after death. <u>9/11/84</u> to <u>9/14/84</u> , that (I) <u>do</u> last and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <u>Norman R. Freeman, Jr.</u>		DEGREE MD		22c. DATE SIGNED 9/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Norman R. Freeman, Jr., MD		22e. ADDRESS 4300 N. Charles St., Balto., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/7/84	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD	
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212			25a. DATE REC'D. BY REGISTRAR SEP 6 1984	25b. REGISTRAR'S SIGNATURE <u>Gelia Davidson-Randall</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

23583

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROSELLA</b>		FIRST (ROSELLA) MIDDLE LAST <b>GLAZER</b>		20. DATE OF DEATH MONTH DAY YEAR <b>9 7 84</b>		2b. HOUR <b>148 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 4, 1909</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>75</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO. CO. GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <b>AARON</b>		MIDDLE <b>OSTROWSKY</b>		15. MOTHER'S MAIDEN NAME <b>REBECCA</b>		MIDDLE <b>RACHEL</b> LAST <b>BOLTANSKY</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-48-9727</b>		17. INFORMANT <b>JOE GLAZER</b> ADDRESS <b>914 PAINTED POST RD. #21208</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <b>COMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INTRACEREBRAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DUODENAL ULCER</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <b>Hafeez P. Saeed</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/7/84</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAFAEEZ SYE1</b>				22e. ADDRESS <b>BALTIMORE COUNTY 4 GEN</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-9-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 8 9

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPH BERNARD J. GLYNN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9 9 84</b>		2b. HOUR <b>2:30AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 9 1905</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ireland</b>		8. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N. CHARLES STREET-GBMC</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Oil Co.</b>		13a. STATE <b>Maryland</b>	
13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>212 Longwood Rd. 21210</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin Glynn</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary McDermott</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>216-03-6586</b>		17. INFORMANT <b>John M. Glynn</b>		ADDRESS <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE OF INJURY <b>AUG. 2 84</b>		21h. DATE OF DEATH <b>SEPT. 9 84</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 9 19 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.					
22b. SIGNATURE <b>David C. Roberts</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/9/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. DAVID ROBERTS M.D.</b>		22e. ADDRESS <b>6701 N. CHARLES STREET-GBMC</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 12, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>	
25b. REGISTRAR'S SIGNATURE <i>John T. ...</i>					

MEDICAL CERTIFICATION

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1 - FOR  
STATE  
REGISTRAR

REG. NO.

8 4 2 3 5 9 0

1 DECEASED NAME (TYPE OR PRINT) <b>Anne Pauline Goettner</b>				2a DATE OF DEATH MONTH DAY YEAR <b>Sept. 22 1984</b>				2b HOUR <b>2:05 PM</b>	
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan. 28 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>			
10 CITY OR TOWN OF DEATH <b>Kingsville</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7418 Goettner Rd. 21087</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House wife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home - Keeping</b>	
13a STATE <b>Md.</b>				13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Kingsville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Albert Schroeder</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Weber</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>215-12-9496A</b>		17 INFORMANT ADDRESS <b>7418 Goettner Rd.</b> <b>Mr. Frank C. Goettner, Kingsville, Md. 21087</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>multiple metastasis to GI tract</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer Breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Multiple Myeloma</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from _____, 19____, to <b>Sept. 1984</b> , the (1) (we) lost saw the deceased alive on <b>Aug. 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.									
22b SIGNATURE <b>William A. Tyson</b>				DEGREE <b>M.D.</b>				22c DATE SIGNED <b>9-22-84</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>William A. Tyson M.D.</b>				22e ADDRESS <b>P.O. Box 158 Kingsville Md. 21087</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>9-26-1984</b>		23c NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gar.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford Md.</b>			
24 FUNERAL DIRECTOR NAME <b>E.F. Lassah</b>				ADDRESS <b>11750 Belair Rd. Kingsville, Md. 21087</b>		25a DATE REC'D. BY REGISTRAR <b>OCT 01 1984</b>		25b REGISTRAR'S SIGNATURE <b>Julian Swiderski</b>	

BP

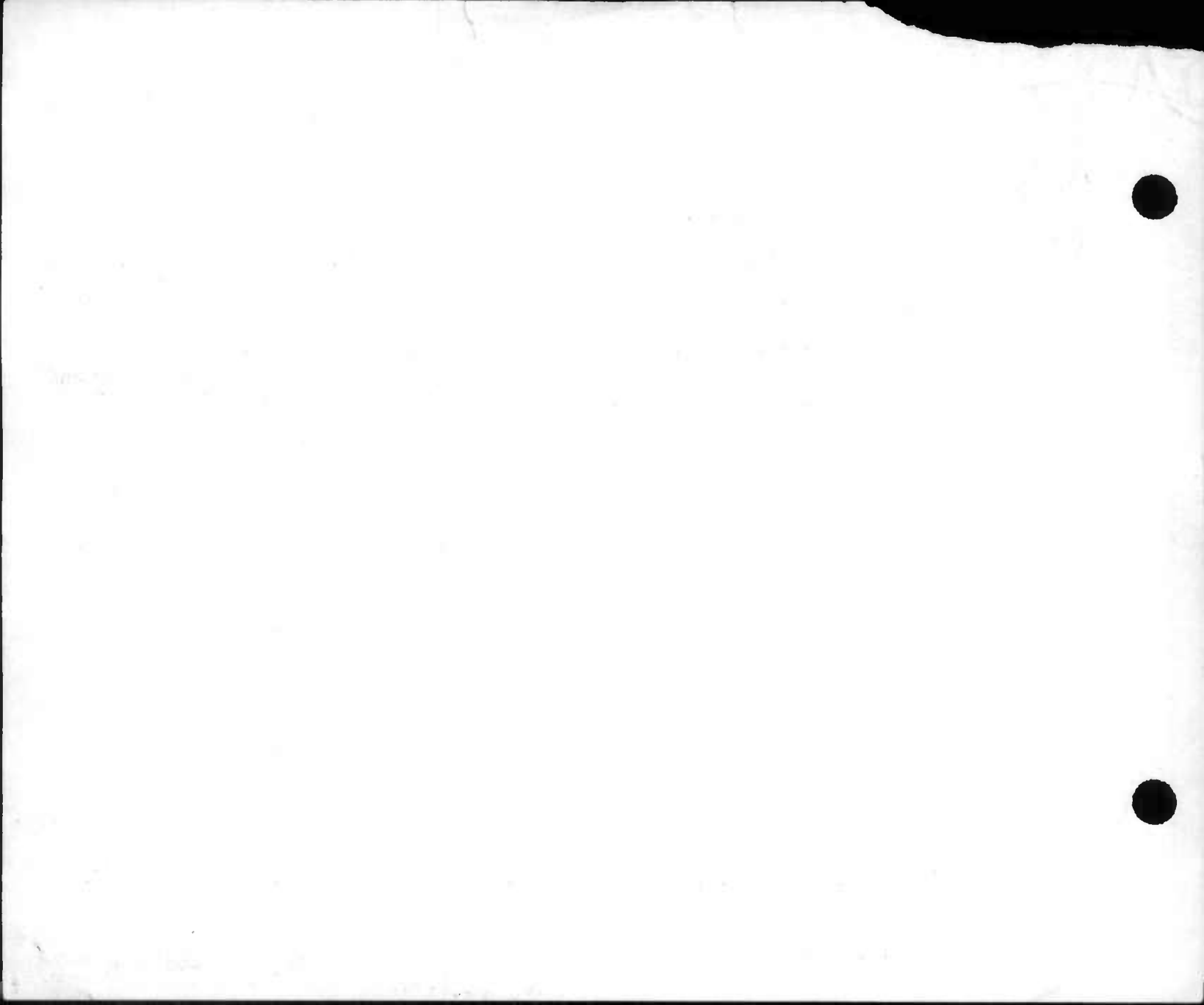


Handwritten notes and text, mostly illegible due to blurriness. Some visible words include "18", "20", "21", "22", "23", "24", "25", "26", "27", "28", "29", "30", "31", "32", "33", "34", "35", "36", "37", "38", "39", "40", "41", "42", "43", "44", "45", "46", "47", "48", "49", "50", "51", "52", "53", "54", "55", "56", "57", "58", "59", "60", "61", "62", "63", "64", "65", "66", "67", "68", "69", "70", "71", "72", "73", "74", "75", "76", "77", "78", "79", "80", "81", "82", "83", "84", "85", "86", "87", "88", "89", "90", "91", "92", "93", "94", "95", "96", "97", "98", "99", "100".

Handwritten notes and text, mostly illegible due to blurriness. Some visible words include "101", "102", "103", "104", "105", "106", "107", "108", "109", "110", "111", "112", "113", "114", "115", "116", "117", "118", "119", "120", "121", "122", "123", "124", "125", "126", "127", "128", "129", "130", "131", "132", "133", "134", "135", "136", "137", "138", "139", "140", "141", "142", "143", "144", "145", "146", "147", "148", "149", "150", "151", "152", "153", "154", "155", "156", "157", "158", "159", "160", "161", "162", "163", "164", "165", "166", "167", "168", "169", "170", "171", "172", "173", "174", "175", "176", "177", "178", "179", "180", "181", "182", "183", "184", "185", "186", "187", "188", "189", "190", "191", "192", "193", "194", "195", "196", "197", "198", "199", "200".

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 2 3 5 9 1  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Edwin Henry GOLDIE								Sept. 18, 1984								5:00AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Male		White		June 21, 1927		57 YRS.		New York		U.S.A.		Baltimore County, MD.		Rosedale		1410 Lancelot Drive	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12c. KIND OF BUSINESS OR INDUSTRY		12d. INSIDE CITY LIMITS?		12e. STREET ADDRESS / ZIP CODE		12f. BALTIMORE CITY OR COUNTY OF DEATH		12g. BALTIMORE CITY OR COUNTY OF DEATH		12h. BALTIMORE CITY OR COUNTY OF DEATH		12i. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		Management		Balto. City.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1410 Lancelot Drive 21237		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
13a. FATHER'S NAME (FIRST)		13b. FATHER'S NAME (MIDDLE)		13c. FATHER'S NAME (LAST)		13d. MOTHER'S MAIDEN NAME (FIRST)		13e. MOTHER'S MAIDEN NAME (MIDDLE)		13f. MOTHER'S MAIDEN NAME (LAST)		13g. MOTHER'S MAIDEN NAME (FIRST)		13h. MOTHER'S MAIDEN NAME (MIDDLE)		13i. MOTHER'S MAIDEN NAME (LAST)	
Maurice		Shields		Goldie		Constance Loretta Rowe											
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		14b. SOCIAL SECURITY NO.		14c. INFORMANT		14d. ADDRESS		14e. ADDRESS		14f. ADDRESS		14g. ADDRESS		14h. ADDRESS		14i. ADDRESS	
Yes		WW2-Korea		212-22-1459		Mary Goldie		1410 Lancelot Drive		21237							
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		15a. PART 1. DEATH WAS CAUSED BY:		15b. IMMEDIATE CAUSE (a)		15c. DUE TO, OR AS A CONSEQUENCE OF		15d. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST		15e. DUE TO, OR AS A CONSEQUENCE OF		15f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		15g. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		15h. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				cardio-respiratory arrest								hours					
				myocardial infarction								years					
				hypertension													
16. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		16a. DATE OF OPERATION		16b. CONDITION FOR WHICH OPERATION WAS PERFORMED		16c. AUTOPSY?		16d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		16e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		16f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		16g. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		16h. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
17a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		17b. TIME OF INJURY		17c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		17d. INJURY OCCURRED		17e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		17f. LOCATION		17g. CITY OR TOWN		17h. COUNTY		17i. STATE	
		HOUR A.M. MONTH DAY YEAR				P.M. 19				STREET							
18a. I certify that (I) (this hospital) attended the deceased from		18b. DATE		18c. DATE		18d. DATE		18e. DATE		18f. DATE		18g. DATE		18h. DATE		18i. DATE	
5/23		19		84		and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>viewed</del> (did not) view the body after death.											
19a. SIGNATURE		19b. DEGREE		19c. ATTENDING PHYSICIAN		19d. MEDICAL DIRECTOR		19e. STAFF PHYSICIAN		19f. DATE SIGNED		19g. DATE SIGNED		19h. DATE SIGNED		19i. DATE SIGNED	
Michael J. Quinn		MD		XX		XX				Sept 18, 1984							
20a. PHYSICIAN'S NAME (TYPE OR PRINT)		20b. ADDRESS		20c. ADDRESS		20d. ADDRESS		20e. ADDRESS		20f. ADDRESS		20g. ADDRESS		20h. ADDRESS		20i. ADDRESS	
Michael J. Quinn, M.D.		1005 North Point Blvd.		Baltimore, Md.													
21a. BURIAL, CREMATION, REMOVAL (SPECIFY)		21b. DATE		21c. NAME OF CEMETERY OR CREMATORY		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE		21h. DATE REC'D. BY REGISTRAR		21i. REGISTRAR'S SIGNATURE	
Burial		Sept 21, 84		Parkwood Cemetery		Baltimore, Md.								SEP 19 1984		Julia Davidson-Randall	
22a. FUNERAL DIRECTOR		22b. NAME		22c. ADDRESS		22d. ADDRESS		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS		22i. ADDRESS	
		Doppel Funeral Homes, Inc.		7110 Belair Road		Baltimore, Md.											



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 4 2 3 5 9 2

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Elizabeth Goldman			2a. DATE OF DEATH MONTH DAY YEAR September 1, 1984		2b. HOUR 2:30A M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 21, 1934	6. AGE (IN YEARS LAST BIRTHDAY) 50 years old YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8403 Charlton Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Holiday Health Spa		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Randallstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Howard P. Grauling			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen E. Grauling		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---		16b. SOCIAL SECURITY NO. 219-28-4315	17. INFORMANT ADDRESS Cheryl Clem 28 Bon Bon Court Reisterstown, MD 21136		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of the Breast</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-20-60</u> , 19____, to <u>present</u> , 19____, that (I) (we) last saw the deceased alive on <u>8-17-84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jerome H. Ginsberg</u> M. D.				22c. DATE SIGNED 9-1-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerome H. Ginsberg, M. D.				22e. ADDRESS 5310 Old Court Road Randallstown, Md. 21133	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 1, 1984	23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation Ser.		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Maryland
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133-4784			25a. DATE REC'D. BY REGISTRAR SEP 6 1984		
			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

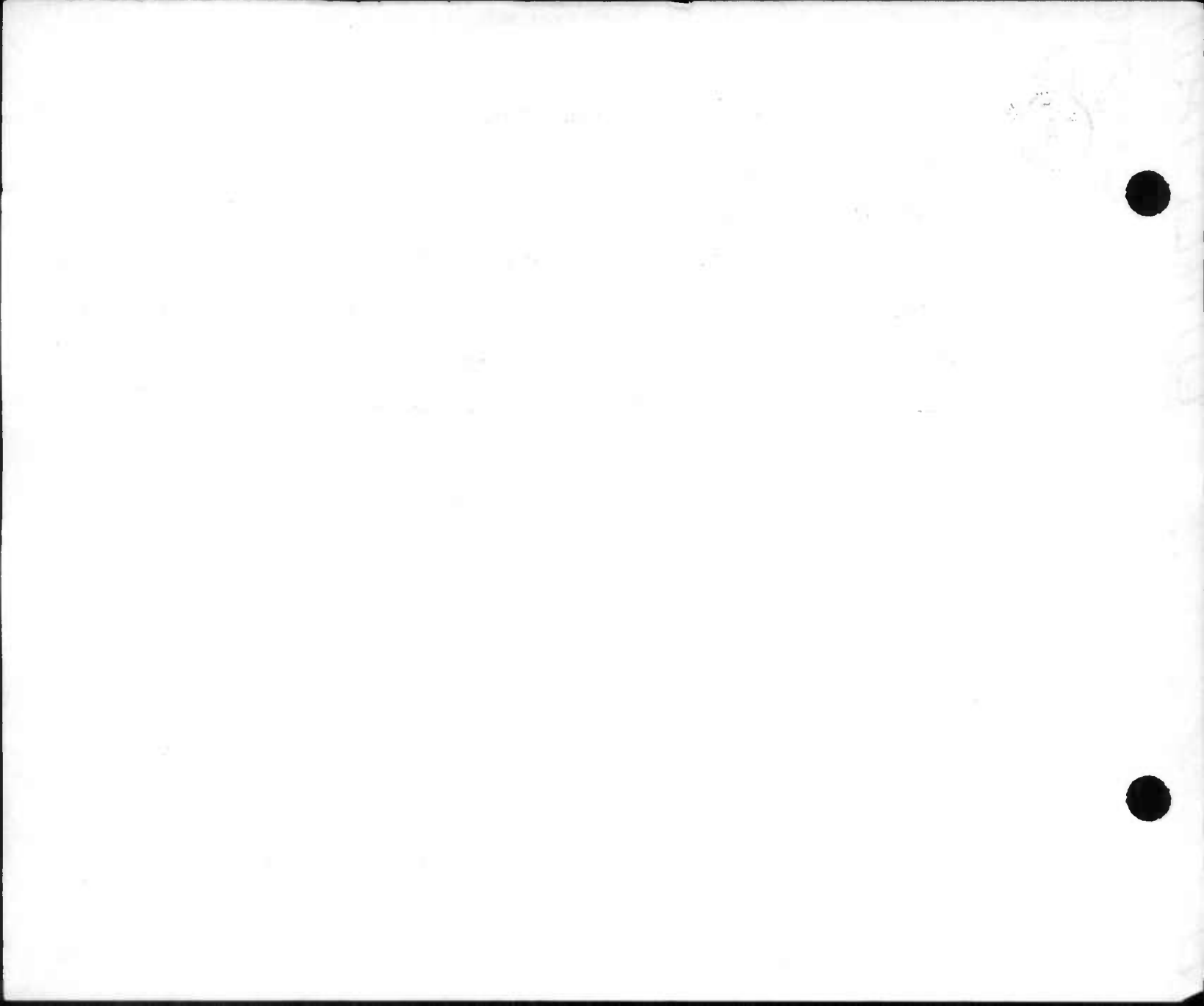
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																								
1 - FOR STATE REGISTRAR					REG. NO. 6 4 2 3 5 9 3																			
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR														
FIRST MIDDLE LAST <b>LOUSIA GOLDSBOROUGH</b>					MONTH DAY YEAR <b>09 05 '84</b>					HOUR MIN. <b>7:35 A</b>														
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.											
Female		White		MONTH DAY YEAR <b>7 11 01</b>			83 YRS.			MONTHS DAYS HOURS MIN.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																	
Maryland		U.S.					BALTIMORE COUNTY, MD.																	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY												
TOWSON				GREATER BALTIMORE MEDICAL CENTER				Secretary				Transportation												
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS / ZIP CODE				
Md.					Towson					YES <input type="checkbox"/> NO <input type="checkbox"/>					615 Chestnut Ave. 21204									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT				
FIRST MIDDLE LAST <b>Harvey Goldsborough</b>					FIRST MIDDLE LAST <b>Estella Short</b>										ADDRESS <b>Brandywine Summit Camp #2 Centerville, Delaware</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.)					IMMEDIATE CAUSE (a) <b>CARDIAC SHOCK</b>					DUE TO, OR AS A CONSEQUENCE OF (b) <b>LEFT VENTRICULAR FAILURE AND HYPOVOLEMIA</b>					DUE TO, OR AS A CONSEQUENCE OF (c)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
					HOUR A.M. MONTH DAY YEAR P.M. 19																			
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION														
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from <b>9/5</b> 19 <b>84</b> to <b>9/5</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>9/5</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										DEGREE					22c. DATE SIGNED									
<b>Peter N. Townsend</b>															<b>9-5-84</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS														
<b>PETER TOWNSEND, M.D.</b>										<b>GBMC - 6701 N. CHARLES STREET 21204</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION									
Removal					9/5/84										CITY OR TOWN COUNTY STATE									
24. FUNERAL DIRECTOR										25a. DATE RECD. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
NAME ADDRESS <b>Anatomy Board Balto., Md.</b>										<b>SEP 13 1984</b>					<b>John Davidson-Randall</b>									

BP





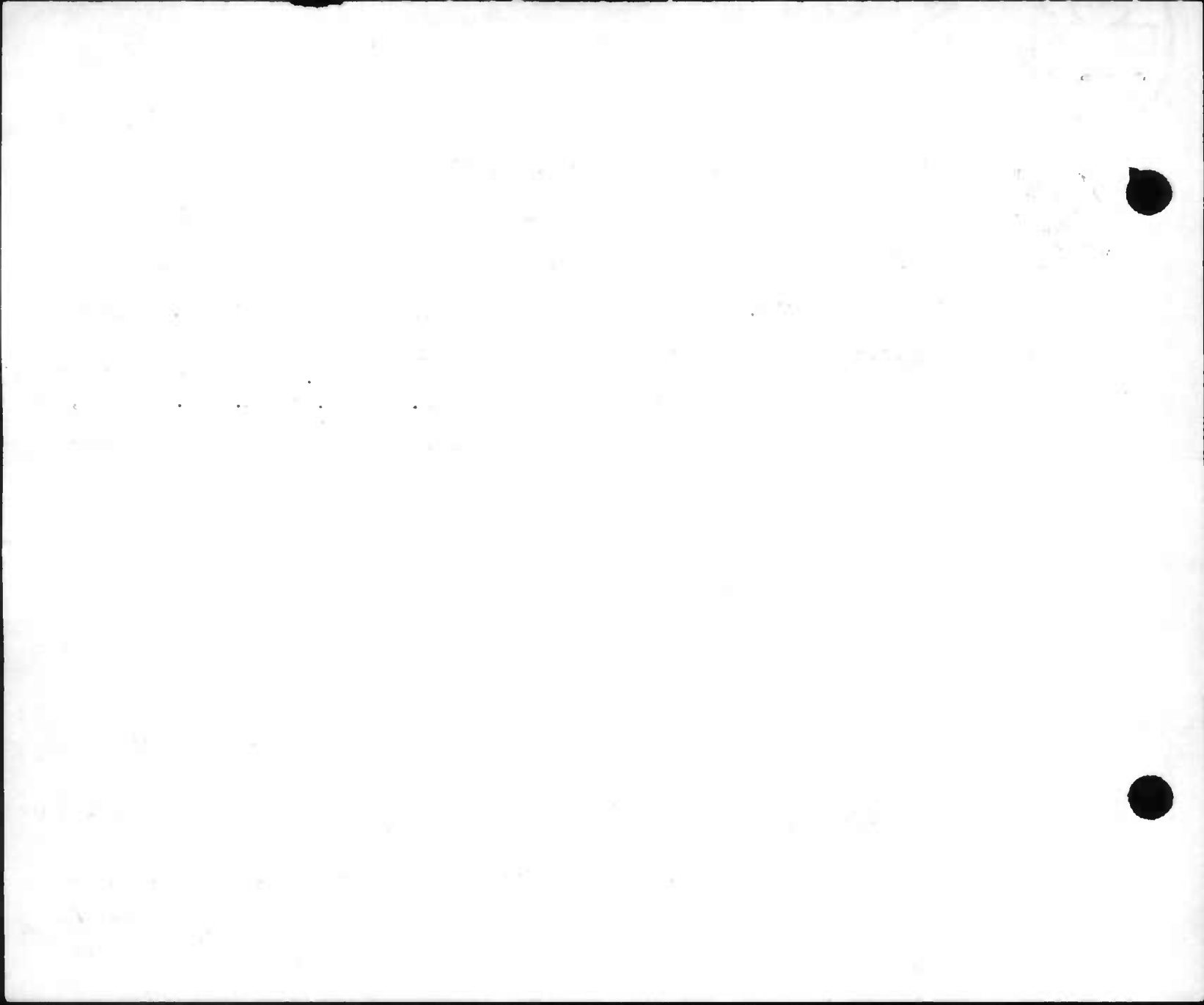
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 9 4

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Rebecca</b> <b>Gordon</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>September 24, 1984</b>		2b. HOUR <b>7:00 P.M.</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 12, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3823 CORONADO RD.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRINCIPAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3823 CORONADO RD. #21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSHUA</b> <b>EHUD IN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA</b> <b>DINKIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-40-3199</b>		17. INFORMANT <b>STEPHEN M. EHUDIN</b> <b>505 ALEXANDER BROWN BLDG. 102 W. PENNA. AVE. TOWSON, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>carcinoma breast</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mths</b> <b>2 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ASCD</b>					
19a. DATE OF OPERATION <b>9/24</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ASCD</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/24</b> 19 <b>84</b> , to <b>9/24</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/24</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Maurice Feldman MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/23/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAURICE FELDMAN, M.D.</b>		22e. ADDRESS <b>6610 CROSS COUNTRY BLVD. BALTO., MD</b>			
23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>Burial</b>	23b. DATE <b>Sept 26/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Beth El</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rondelstown, Maryland</b>		
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros - 6010 Reisterstown Rd</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

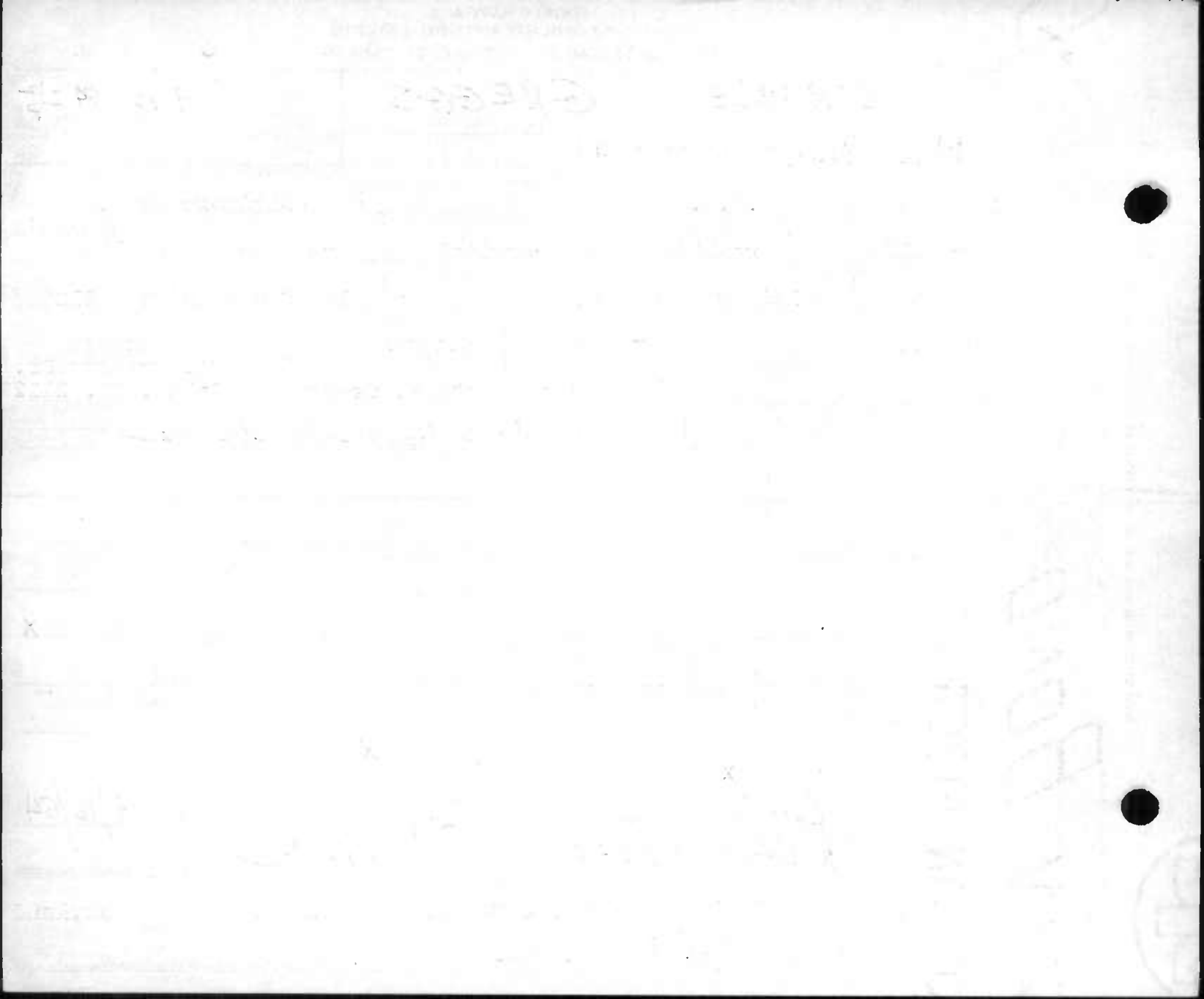


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR		23595										
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH			2b. DATE ESTI- MATED		2c. DATE PRONOUNCED DEAD	
STRUBLE GREGGS						9 12 19 84			2 12 PM		19 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		
Male		White		2 10 1943		41 YRS.		MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		
Pennsylvania		U.S.A.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR OCCUPATION				
Rossville		Franklin Square Hospital				Bartender		Mother's Place				
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland				Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8106 Coyne Drive 21222		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						
Kenneth Greggs						Kathryn Struble						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT				7886 St. Gregory Dr. Balto., MD. 21222		
No				219-40-7647		John T. Greggs						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) (stating the underlying cause last.)												
(b) <u></u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c) <u></u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED				
R. BREITENECKER				M.D. Dep.				9/12/84				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				BB MC				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial				9/17/1984		Moreland Memorial		Baltimore Maryland				
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Duda-Ruck, Inc.				9 SEP 11 1984				[Signature]				
7922 Wise Avenue				Dundalk, MD. 21222								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <i>Jane E. Grill</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>9-14-84</i>		2b. HOUR <i>4:35 P.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>February 21 1890</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>94</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore Co.</i> MD.			
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Manor Care Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HWF</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Reisterstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>14946 Dover Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Daniel W. Myers</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Rigler</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>219-58-6102</i>		17. INFORMANT ADDRESS <i>Mrs. Helen Hagan, Reisterstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arterio-sclerotic Cardio Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterio-sclerotic Degeneration for many years</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <i>old 7 years</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11 P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>11 Spinal TB</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>11 Spinal TB</i> , 19 <i>78</i> , to <i>19</i> , that (I) (we) lost saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Walter T. Kees</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Walter T. Kees</i>				22e. ADDRESS <i>Moulton MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9-17-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Grove Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Upperco Balto Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Eline Funeral Home, Hampstead, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 17 1984</i>		25b. REGISTRAR'S SIGNATURE <i>J. L. ...</i>			

1725

489 517

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the Health Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 84 23597

1 DECEASED NAME (TYPE OR PRINT) <b>EUGENIA GRIMM</b>			2a DATE OF DEATH MONTH DAY YEAR <b>September 23, 1984</b>			2b HOUR <b>6:35P M</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>August 1, 1920</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>			
10 CITY OR TOWN OF DEATH <b>Woodlawn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5513 Bosworth Road</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Social Services</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Woodlawn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>5513 Bosworth Road 21207</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Stanley</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva Peart</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-18-4220</b>		17 INFORMANT <b>Mary Alice Davis</b>		ADDRESS <b>5515 Bosworth Road Baltimore, Md. 21207</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Coral Gordon</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>9-25-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Coral Gordon M.D.</b>				22e. ADDRESS <b>2122 Pat Spring Rd. Timonium Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/27/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Md.</b>			
24 FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			
1630 Edmondson Avenue, Catonsville, Md. 21228									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IRVIN H. GROLLMAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9-13-84</b>		2b. HOUR <b>4:25</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 28, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS <b>7</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER CO.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>605 LEAFYDALE TERR. #21208</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY GROLLMAN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JEAN UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-26-4833A</b>		17. INFORMANT <b>MRS. FREDA GROLLMAN</b> <b>605 LEAFYDALE TERRACE #21208</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <b>MULTIPLE SCLEROSIS</b>									
19a. DATE OF OPERATION <b>9-5-84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>9-5-84</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-5-84</b> to <b>9-13-84</b> , that (I) (we) lost saw the deceased alive on <b>9-13-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Orlando B. Conanan</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>9-13-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ORLANDO B. CONANAN, MD</b>				22e. ADDRESS <b>BCHH - RANDALLSTOWN Md. 21133</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>SEPT. 14, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>			

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**RETURN TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE MEDICAL EXAMINER. PAGES 4 AND 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **RETURN TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WEST PRISON STREET, INDIANAPOLIS, INDIANA 46202. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WEST PRISON STREET, INDIANAPOLIS, INDIANA 46202. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WEST PRISON STREET, INDIANAPOLIS, INDIANA 46202.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										23599 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LILLY H. GROLOCK</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>September 1984</b>				2b. HOUR M A	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 2, 1893</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>91 YRS.</b>		7. IF UNDER 1 YR MONTHS DAYS <b>0 0</b>		7. IF UNDER 24 HRS HOURS MIN <b>0 0</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				9b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>			
12b. KIND OF BUSINESS OR INDUSTRY <b>Drug Co.</b>				13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>			
13c. CITY OR TOWN <b>Timonium</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>211 Burning Tree Rd. 21093</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gustav Grolock</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Augusta Discher</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>214-01-8753</b>				17. INFORMANT ADDRESS <b>Evelyn G. DeBaugh - Same as #13e</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforated Duodenal Ulcer &amp; Peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Fractured Rt Hip</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD with Senility</b>			
18. CAUSE OF DEATH (continued) CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>8880</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 Day</b> <b>4 wks.</b> <b>5+ yrs</b>				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Fractured R Hip</b>			
19a. DATE OF OPERATION <b>8-29-84</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fractured R Hip</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>12 PM Aug 28 1984</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12 PM Aug 28 1984</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell in Room in Nursing Home</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <b>Nursing Home</b>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Chesapeake</b>				21f. LOCATION CITY OR TOWN COUNTY STATE <b>Towson Baltimore Md</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										22b. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE <b>Charles F. O'Connell</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles F. O'Connell</b>				ADDRESS <b>1050 York Rd.</b>				DATE SIGNED <b>9/25/84</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>9-27-84</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>			
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Baltimore, Maryland</b>				24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>			
25b. REGISTRAR'S SIGNATURE <b>W. W. W. W.</b>				25c. REGISTRAR'S SIGNATURE <b>W. W. W. W.</b>				25d. REGISTRAR'S SIGNATURE <b>W. W. W. W.</b>			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 6 0 0

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anna H. Gurecki			2a. DATE OF DEATH MONTH DAY YEAR 9 8 84		2b. HOUR 6:00P <sup>AM</sup>
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 21 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	# UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Dundalk	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1731 Burnham Road 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Not Known Zavistowski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-74-8431		17. INFORMANT ADDRESS Jean M. Hollar Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 1, 19 69</u> to <u>Sept. 9, 19 84</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Ther. Patterson</u>		DEGREE THEO. C. PATTERSON, M.D.		22c. DATE SIGNED 9/10/84	
22d. PHYSICIAN'S NAME (PRINT) 3427 DUNDALK AVE.		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL, ETC. (SPECIFY) Burial		23b. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23c. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222		25a. DATE REC'D. BY REGISTRAR SEP 10 1984		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Rundle</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 8 4 2 3 6 0 1							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH CHARLES GUTBERLET						2a. DATE OF DEATH MONTH DAY YEAR September 26, 1984		2b. HOUR 6:20P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 10 <sup>th</sup> 1900 <sup>r</sup>		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Monkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 14906 Dunston Lane 21111				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY Legal	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Monkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14906 Dunston Lane 21111	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Aloysius Gutberlet				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Walls					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-01-4553		17. INFORMANT ADDRESS Dr. R.L.Gutberlet 10837 Sandringham Rd. 21030					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ARTERIOSCLEROTIC HEART DISEASE</u>									
19a. DATE OF OPERATION <u>-</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>-</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>-</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>8/5</u> , 19 <u>88</u> , to <u>9/26</u> , 19 <u>84</u> (tho) (h) (tw) last saw the deceased alive on <u>8/5</u> , 19 <u>84</u> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ramon Roig</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>9/27/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ramon F. Roig				22e. ADDRESS 7600 Osler Drive 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-29-84		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home				ADDRESS 6500 York Road 21212		25a. DATE REC'D. BY REGISTRAR OCT 2 1984		25b. REGISTRAR'S SIGNATURE <u>J. H. Davidson-Randell</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS, LAST BIRTHDAY)	
Marion		Female		White		9-1-11		73 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOUR	
Maryland		U.S.A.				Baltimore County		5:15P M	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS OR INDUSTRY			
Towson		Multi-Medical Center		Secretary		Insurance			
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. INSIDE CITY LIMITS?		16. STREET ADDRESS / ZIP CODE					
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE					
Maryland		Baltimore		4620 Crosswood Ave 21214					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Joseph H. Grullemeyer		Emma B. Barth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		216-07-7500		Mr. J.W. Haddock Jr.		4620 Crosswood Ave 21214			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:		Generalized Metastasis		Adenocarcinoma of sigmoid colon metastatic to pericolic fat				11/9/82	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from		Sept 1, 1983, to		9/3/1984, that (I) (we) last saw the deceased alive on		Aug 22, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Dr. Allen B. Cohen						9/4/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Dr. Allen Cohen		201 E. University Pkwy.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
Burial		9-6-84		Loudon Park		Baltimore		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Mitchell-Wiedefeld Home 6500 York Road 21212		SEP 5 1984		Davidson					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

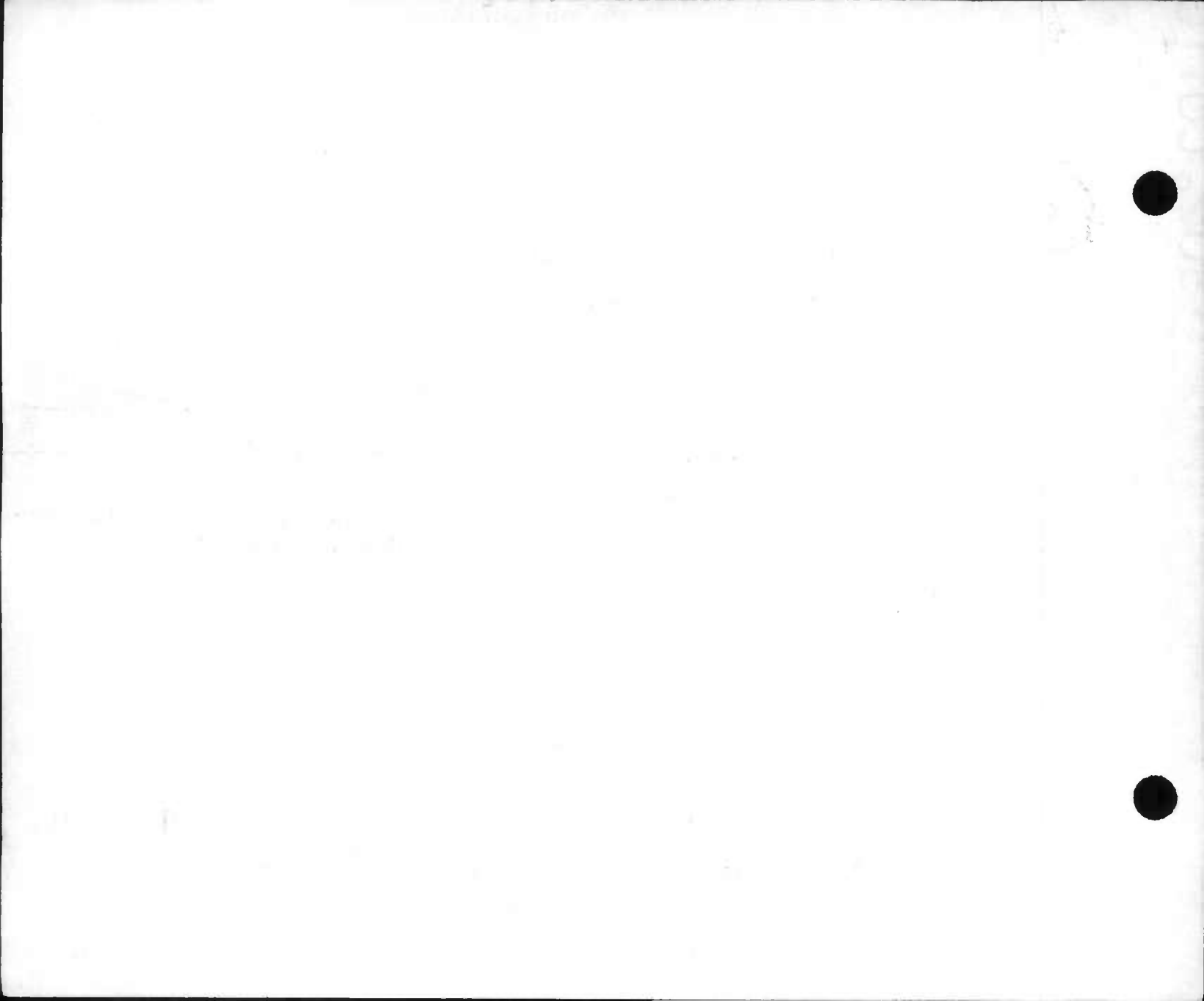
1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES HALL</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>21</b> YEAR <b>84</b>			2b. HOUR <b>2216</b> M			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>14</b> YEAR <b>13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ala.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodlawn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e. STREET ADDRESS / ZIP CODE <b>2006 Woodlawn Dr. 21207</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-01-0763</b>		17. INFORMANT ADDRESS <b>Carolyn David 5218 Saybrook Rd.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden death Secondary to</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery diseases, History</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction with Cardiac Arrhythmia and pulmonary edema</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>History of Hypertension</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 19 84</b> to <b>9-21-19 84</b> ; that (I) (we) lost saw the deceased alive on <b>9-21-19 84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R.M. Shah, M.D.</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/25/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.M. SHAH.</b>						22e. ADDRESS <b>5310 OLD COURT RD. RANDALLSTOWN, MD 21132</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/27/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY MD <b>Baltimore</b>		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Chia Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

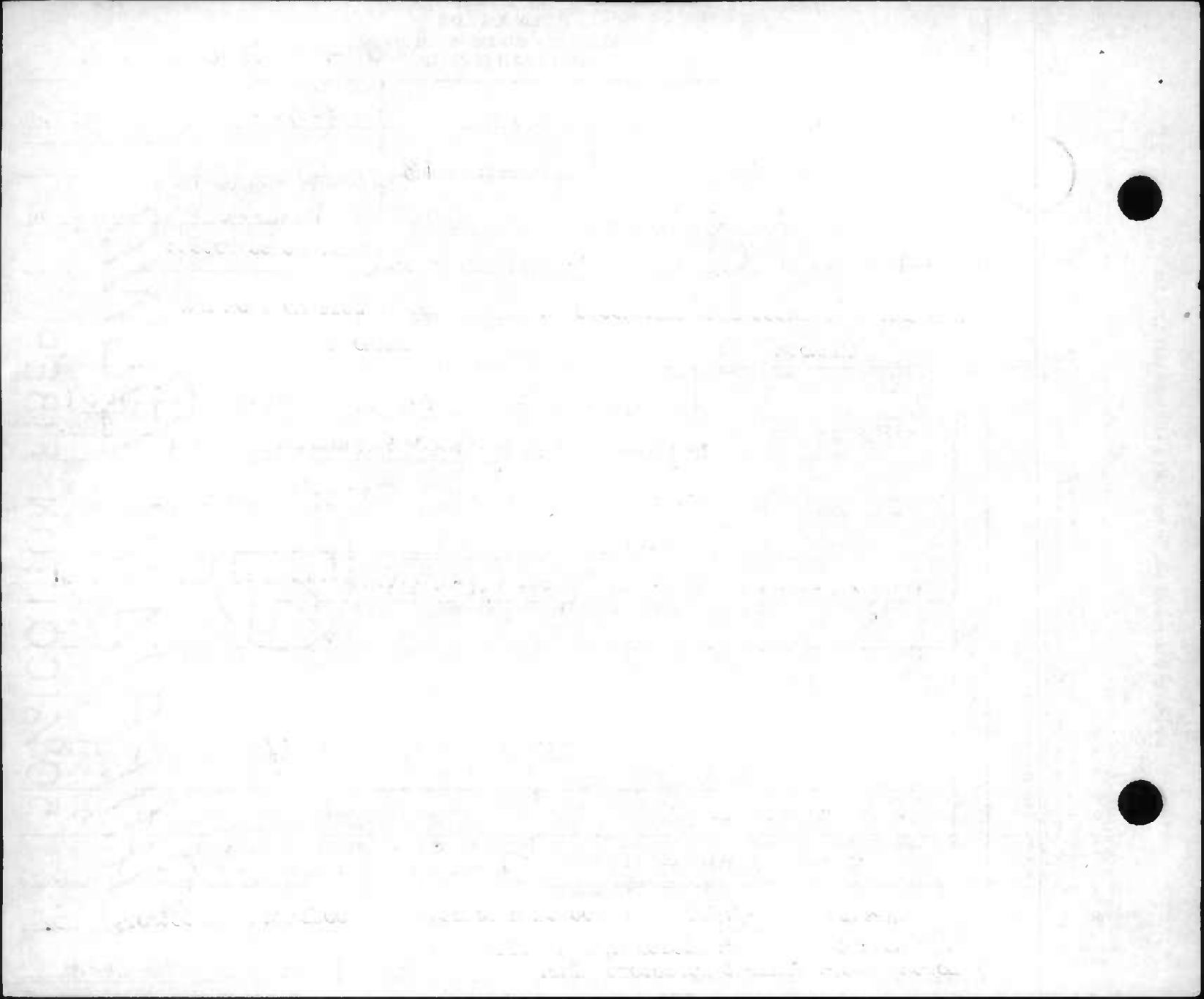
1. DECEASED NAME (TYPE OR PRINT) James S. Hall			2a. DATE OF DEATH MONTH DAY YEAR 9-4-84			2b. HOUR 10:50 PM				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 6-11-48		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE COUNTRY Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chapel Hill Convalescent Home				12a. USUAL OCCUPATION (TYPE WORK FORM OR FOR WORK) MD. State Police		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5511 Roboson Rd. 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-12-0251		17. INFORMANT Ruth B. Doolan		ADDRESS 3817 Offutt Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction with pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Presence of chronic Diseases and DUE TO, OR AS A CONSEQUENCE OF (c) P.A.U. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Degenerative Diseases of cerebral Arteriosclerosis for multiple myeloma										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/1/83, 19 to 9/1/84, 19 that (I) (we) lost saw the deceased alive on 8/31/84, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R-M-Shah M.D.					DEGREE		22c. DATE SIGNED 9/1/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R-M. SHAH M.D.					22e. ADDRESS 5310 Old Court Rd Randallstown, MD 21133					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/7/84		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD.			
24. FUNERAL DIRECTOR 8724 Liberty Rd. Randallstown, MD. 21133 X Loring Byers Funeral Directors Inc.					25a. DATE REC'D. BY REGISTRAR SEP 11 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 23605

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Marie C. Harris</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 26, 1984</b>		2b. HOUR <b>1:00 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 19, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>74</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7908 Oakdale Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>7908 Oakdale Avenue 21234</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>William F. Dovell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nora - O'Sullivan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-18-4078</b>		17. INFORMANT ADDRESS <b>Mr. William E. Harris Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>45CVD and Deacon Comes</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4/82</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4/82</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/7</b> , 19 <b>82</b> to <b>9/26</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/8</b> , 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Wm C Waterfield</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/27/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William C. Waterfield MD</b>				22e. ADDRESS <b>900 Caton Avenue Baltimore, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 29, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 27 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Dawson Hande</b>	

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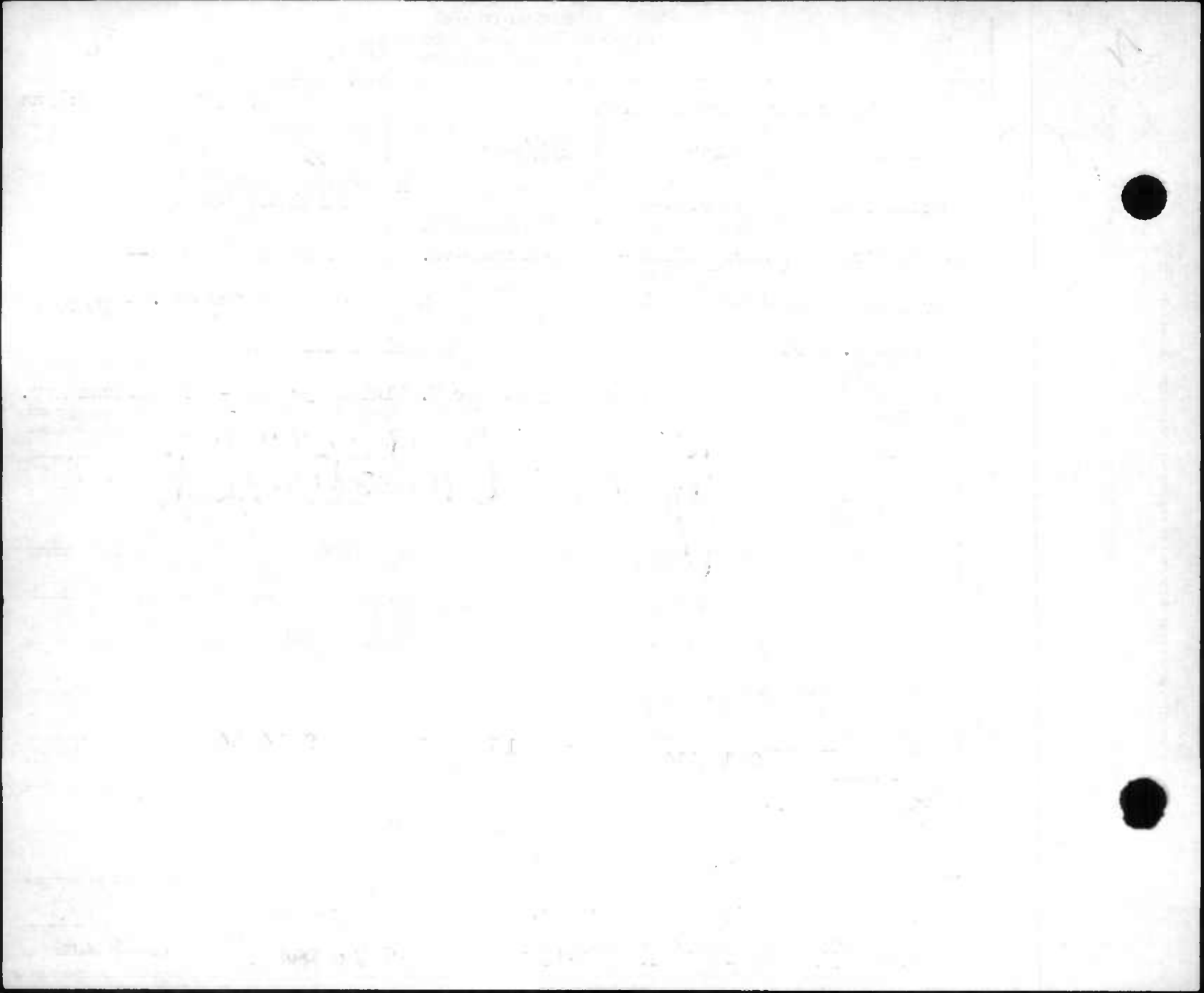
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. FOR STATE REGISTRAR					REG. NO. 23006									
1. DECEASED NAME (TYPE OR PRINT) <b>Sister Mary Marcella Hart</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9/24/84</b>					2b. HOUR MIN. <b>9:15am</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2/7/89</b>			6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>95</b>			IF UNDER 1 YEAR MONTHS DAYS <b>95</b>		IF UNDER 24 HRS. HOURS MIN. <b>95</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oakland, MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>America-US</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.						
10. CITY OR TOWN OF DEATH <b>Rodgers Forge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Villa -6806 Bellona Ave.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>						
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore Co</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6806 Bellona Ave. -21212</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John W. Hart</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Marie Helbig Hart</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-54-2672</b>		17. INFORMANT ADDRESS <b>Sister M. Elaine Costello-6806 Bellona Ave.</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dissecting Aortic Aneurysm</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (the husband) attended the deceased from <b>Jan 16, 1968</b> , to <b>9/24/84</b> , 19____, that (I) (we) last saw the deceased alive on <b>9/10/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.														
22b. SIGNATURE <b>[Signature]</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVIS</b>					22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/26/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Mitchell - Wiedefeld Home Inc.</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							
6500 York Rd., Baltimore, Md. 21212														



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 6 0 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>AUGUSTA Gill HARTHAUSEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 27 '84</b>		2b. HOUR <b>2:30A</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 7 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Milliner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Sales</b>			
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Timonium</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2306 Chetwood Circle, 21093</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Franz Gill</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Sander</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>		16b. SOCIAL SECURITY NO. <b>217-14-1421A</b>		17. INFORMANT ADDRESS <b>Francis Gill, 1205 Mt. Carmel Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ISCHEMIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROSIS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/27</b> <b>84</b> to <b>9/27</b> <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/27</b> <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <b>9/27/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ENRIZIO LOBATO.</b>		22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9/29/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>		ADDRESS <b>10 W. Padonia Rd. 21093</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1984</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

A

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO: Mr. J. Edgar Hoover  
FROM: Mr. [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[illegible text continues]

[illegible text continues]

[illegible text continues]

[illegible text continues]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 3 6 0 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Freda E. Hartzell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 11 84</b>		2b. HOUR <b>4 30 A M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 - 12 - 38</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ind.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris Hospice</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Ind</b>	13c. COUNTY <b>Balto</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>301 S. Woodyear St. 21223</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William W. Blizard</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Freda E. Albaugh</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>88</b>	17. INFORMANT <b>John E. Hartzell III</b> ADDRESS <b>301 S. Woodyear St. 21223</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Metastatic Breast cancer**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>R. Faulkner MD</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9/11/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Faul Kner</b>		22e. ADDRESS <b>Stella Maris Towson Md</b> <b>2300 Delaney Valley Rd. 21204</b>	

23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>9-14-1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lovane Ph. Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Md.</b>
24. FUNERAL DIRECTOR NAME <b>John J. Conner &amp; Son Inc.</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>SEP 17 1984 John Davidson-Randall</b>	

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University of Chicago

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the holder of the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				7b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				7b. HOUR			
FIRST MIDDLE LAST		MONTH DAY YEAR				MONTHS DAYS HOURS MIN.			
ELIZABETH Norris HARVEY		9. 29 84				1:00 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR		77 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore, Md.		USA				Balto. Co.		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown		Balto. Co. Gen. Hospt.				Retired School Teacher			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3811 Canterbury Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Joshua G. Harvey		Bessie Norris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		212-32-1634		Mrs. Anne H. Trimble Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cellulitis left leg; Anaerobic Sepsis</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dementia</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
AT WORK AT WORK									
22a. I certify that (I) (this hospital) attended the deceased from <u>9. 22</u> 19 <u>84</u> , to <u>9. 29</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>9. 29</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Regina A. Rao</u>		MD						9. 29. 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
RAYA RAO G. Rao		Balt County Genl Hospital							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		10/2/84		Greenmount Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS				OCT 1 1984		Jane Davidson-Randall			
Eline Funeral Home Reisterstown, Md.									

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CHIEF





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

6 4 2 3 6 1 0

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LESTER C. HASSELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-19-84</b>		2b. HOUR <b>10:37 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 4 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Armco Steel</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>TOWSON</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>8513 Old Harford Rd. Apt. C 21234</b>
14. FATHER'S NAME <b>Frederick Anthony Hassell</b>		15. MOTHER'S MAIDEN NAME <b>Agnes Virginia Koch</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-09-1804</b>		17. INFORMANT <b>Naoma R. Hassell</b> ADDRESS <b>8513 Apt. C. Harford Rd. 21234</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to the underlying cause (a), stating the underlying cause last. (b) <b>acute respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>severe COPD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9-19 84</b> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-19 84</b> to <b>9-19 84</b> , that (I) (we) last saw the deceased alive on <b>9-19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>NESTOR CARMONA</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9/19/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NESTOR CARMONA, M.D.</b>		22e. ADDRESS <b>6012 Harford Rd. Balto. Md. 21214</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9-22-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Lossahn Funeral Home</b>		4401 BELAIR RD. <b>BALTO. MD. 21254</b>		25a. DATE REC'D. BY REGISTRAR <b>21 1984</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b>

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE S. HAWKINS Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 28 84</b>		2b. HOUR <b>9:20 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 26, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chief Chemist</b>		12b. PHYSICIAN OR INDUSTRY <b>Eastern Stainless Steel</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Boyd Samuel Hawkins</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Brewer</b>		16. SOCIAL SECURITY NO. <b>219-28-3688</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		17. INFORMANT <b>Dorothy M. Adams</b>		18. ADDRESS <b>1 Kafern Drive Apt. 2D Baltimore, Maryland 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>EXTENSIVE ANTI-WALL MYOCARDIAL INFARCTION</b> (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Hafeez A. Syed</b>		DEGREE <b>BALTIMORE COUNTY GEN HOSP.</b>		22c. DATE SIGNED <b>9/28/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAFAEEZ A SYED M.D.</b>		22e. ADDRESS <b>BALTIMORE COUNTY GEN HOSP.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>ENTOMBMENT</b>		23b. DATE <b>10/4/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	
23d. LOCATION CITY OR TOWN <b>Baltimore, Maryland</b>		23e. NAME OF CEMETERY OR CREMATORY <b>Baltimore, Maryland</b>		23f. LOCATION CITY OR TOWN <b>Baltimore, Maryland</b>	
24. FUNERAL HOME TO WHICH REMAINS WERE DELIVERED NAME ADDRESS <b>Nutter &amp; Sons 2501 Gwynns Falls Parkway Funeral Home Inc. Baltimore, Maryland 21216</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Davidson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician or attending physician must sign the certificate and retain it for 24 hours after death. The certificate must be filed with the State Department of Health and Mental Hygiene within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Funeral Home Inc. Baltimore, Maryland 21201  
Nutter & Sons 2801 Gwynns Falls Parkway  
Baltimore, Maryland 21204

ENTOMBMENT 10/1/1984 Robert Memorial Park

Baltimore, Maryland

No.

219-38-3588 Dorothy M. Adams Baltimore, Maryland 21207

Boyd

Samuel

Hawkins

Annie

Brewer

1 Katern Drive Apt. 2 D.

Maryland

Baltimore

X

.

Apt. 2D Baltimore, Md. 21207

1 Katern Drive

Randallstown

Baltimore County General Hosp.

Chief Chemist

Stainless Steel

Eastern

Maryland

U. S. A.

X

Baltimore County

Black

12 28, 1930

Male

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5a should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23612

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MARY		MONTH DAY YEAR		15 PM	
MIDDLE .		Sept. 29, 84			
LAST HAYNIE					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	84	MONTHS DAYS HOURS MIN.	
		May 23, 1900			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	USA		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Towson	St. Joseph's Hospital	Homemaker	Own Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MD		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Apt. E 40T, 6225 York Road, 21212	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
Joseph McKeon	Cecilia Swift				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
No	219 20 5755	Henry Tyson, Balto., MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Ascites due to possible</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic carcinomatosis</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>of liver.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (as a hospital) attended the deceased from 9/15, 19 84, to 9/29, 19 84, that (I) (as a) lost saw the deceased alive on 9/29, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>AH Ghiladi</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		9/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
AH GHILADI		7600 OSLER Dr. Towson 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10/2/84		Holy Redeemer	
				23d. LOCATION CITY OR TOWN COUNTY STATE	
				Balto., MD	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Henry W. Jenkins & Sons Co.		OCT 1 1984		<i>Julia Davidson-Randall</i>	
4905 York Road Balto., MD 21212					

No. 2502

...ctf

NOISE-REDUCING FLOOR

.CO and .V

21212 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078 1079 1080 1081 1082 1083 1084 1085 1086 1087 1088 1089 1090 1091 1092 1093 1094 1095 1096 1097 1098 1099 1100 1101 1102 1103 1104 1105 1106 1107 1108 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121 1122 1123 1124 1125 1126 1127 1128 1129 1130 1131 1132 1133 1134 1135 1136 1137 1138 1139 1140 1141 1142 1143 1144 1145 1146 1147 1148 1149 1150 1151 1152 1153 1154 1155 1156 1157 1158 1159 1160 1161 1162 1163 1164 1165 1166 1167 1168 1169 1170 1171 1172 1173 1174 1175 1176 1177 1178 1179 1180 1181 1182 1183 1184 1185 1186 1187 1188

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				REG. NO.			
CELESTE E. HECKROTTE		9 12 84				3:10 P.M.			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	White	Oct. 17, 1903		80 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MD	USA			Baltimore County MD					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Towson	St. Joseph's Hospital			Homemaker			Own Home		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD		Balto.		Parkville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8707 Ashford Road, 21234	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Joseph W. Cogley			Carrie B. Tusing						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS			
No			212 12 5895			Edward C. Heckrotte, Sr., MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE									
DUE TO, OR AS A CONSEQUENCE OF									
(b) ACUTE C V A									
DUE TO, OR AS A CONSEQUENCE OF									
(c) SEVERE ASCVD									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH -DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 9/12/84 to 9/18/84, and that in my opinion death occurred on the date and hour and from the causes stated above. (If I have not attended, view the body after death.)									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
[Signature]						M.D.		9/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
NESTOR CARMONA, M.D.						St. Joseph's Hospital, Balto., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		9/15/84		Moreland Memorial		Balto. County, MD			
24 FUNERAL DIRECTOR NAME						25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Henry W. Jenkins & Sons Co.						SEP 17 1984		[Signature]	
4905 York Road Balto., MD 21212									

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23614			
1. DECEASED NAME (TYPE OR PRINT) Stephen Michael Hecsko				2a. DATE OF DEATH MONTH DAY YEAR 9/23/84				2b. HOUR 6:35 PM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4/12/02		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. UNDER 1 YEAR MONTHS YEARS		8. UNDER 25 YEARS MONTHS YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria/Hungary		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Jonsom md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Armacost N.H. 812 Regester				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DARBER		12b. KIND OF BUSINESS OR INDUSTRY Self Emp.			
13a. STATE md				13b. COUNTY 1		13c. CITY OR TOWN city		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1035 E. Northwood 21212	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Hecsko				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 188-10-4919		17. INFORMANT ADDRESS Armacost N.H. 812 Regester 21239					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HSCVD, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5+ yrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input type="checkbox"/> AT HOME				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/11/84</u> to <u>9/23/84</u> , that (I) (we) last saw the deceased alive on <u>9/11/84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles O'Donnell</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 9/23/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles O'Donnell				22e. ADDRESS 7501 YORK Rd 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/27/84		23c. NAME OF CEMETERY OR CREMATORY Union Cem. of Heltentown		23d. LOCATION CITY OR TOWN COUNTY STATE Heltentown PA.			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Road						25a. DATE REC'D. BY REGISTRAR SEP 26 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

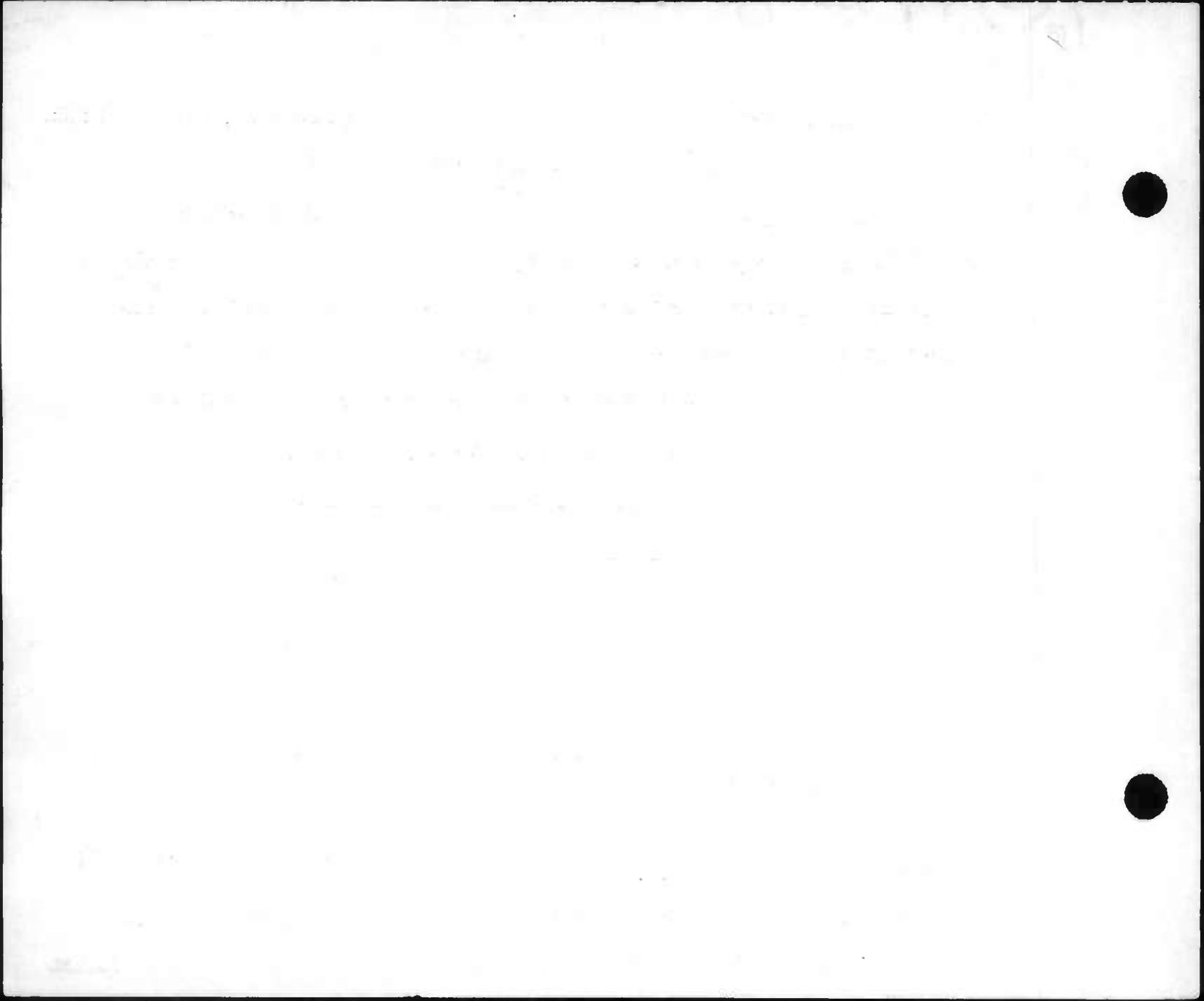
2 3 6 1 5

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH		2b HOUR	
FIRST MIDDLE LAST <b>Clifton HEISE</b>		September 19, 1984		2:05a M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
M	W	5/26/09	75	MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
MD.	USA		Baltimore County MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
ROSSVILLE	FRANKLIN SQ.		FIREMAN		
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE	
MD.	BALTO	ESSEX		21221 918 MARTIN RD	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST CHRISTIAN HEISE		FIRST MIDDLE LAST BERTHA HOLT			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS		
UNK		21509 6204	ANNE HEISE ABOVE		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest, Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ABOVE</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			CITY OR TOWN COUNTY STATE		
22a I certify that <u>X</u> (this hospital) attended the deceased from <u>September 2, 1984</u> , to <u>September 19, 1984</u> , that <u>X</u> (we) lost saw the deceased alive on <u>September 19, 1984</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>XX</u> (we) (did) (not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
<u>J. A. Quansah</u>		M.D.		9/19/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
QUANSAH M.D.		9000 Franklin Square Dr. 21237		FRANKLIN SQUARE HOSPITAL	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION		
BURIAL	9/21/84	OAK LAWN	BALTO. MD.		
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
NAME ADDRESS J. L. CONNELLY 300 MALE		SEP 26 1984		<u>John Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LEATHA M. HENDERSON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9 14 84</b>		2b. HOUR <b>2:50 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 21 1899</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indi Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris Hospice</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALto county</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John</b> <b>Might</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan</b> <b>McNally</b>		13d. STREET ADDRESS <b>4134 Glen Park Road, 21236</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-07-2199-D</b>		17. INFORMANT <b>Bernard E. Henderson, /A Same As #13e 21236</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF 1c) <b>Essential hypertension</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10 10 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/10</b> , 19 <b>80</b> , to <b>9/15</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>9/15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>EDDIE NAKHuda</b>		DEGREE		22c. DATE SIGNED <b>9/14/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDDIE NAKHuda M.D.</b>		22e. ADDRESS <b>Stella Maris Hospice, Towson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-17-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air, Harford, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 18 1984</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>		25b. REGISTRAR'S SIGNATURE <b>Edward Henderson</b>			

02 8 20

RECEIVED

10/10/10

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10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth HERBST</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 27, 1984</b>				2b. HOUR <b>3:32A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 10, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wales</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>		12b. KIND OF BUSINESS OR INDUSTRY -----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Elmwood</b>		13e. STREET ADDRESS / ZIP CODE <b>11 Belinda Avenue 21206</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Morrissey</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eliza Ryall</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-28-1660</b>		17. INFORMANT ADDRESS <b>Albert Herbst 1712 Weston Ave 21234</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 27, 1984</b> , to <b>September 27, 1984</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 27, 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)									
22b. SIGNATURE <b>K. Mason, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9-27-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. Mason, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct 1, 84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Dippel Funeral Homes, Inc.</b>				ADDRESS <b>7110 Belair Road Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1984</b>		25b. REGISTRAR'S SIGNATURE <b>De Davidson-Randall</b>	

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23019	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Robert L. Herrmann Sr.										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 16 19 84	
3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 7 9 1936 6. AGE (IN YEARS) LAST BIRTHDAY 48 YRS.										2b. HOUR 1:58 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A.										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 16 19 84	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2d. HOUR 1:58 P.M.	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.											
10. CITY OR TOWN OF DEATH Towson 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) G.B.M.C.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Account Executive	
12b. KIND OF BUSINESS OR INDUSTRY C.&P. Telephone											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Timonium										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 2118 Forest Ridge Rd. 21093											
14. FATHER'S NAME FIRST MIDDLE LAST Frederick L. Herrmann										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regina A. Krieger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 212-34-2732										17. INFORMANT ADDRESS Margaret H. Herrmann - Same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>Charles + Donald</u> TITLE (SPECIFY) <u>Deputy</u> MEDICAL EXAMINER										DATE SIGNED 9/16/84	
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 9/19/84										23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Baltimore, Maryland											
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. ADDRESS 1050 York Rd. Towson, Md. 21204										25a. DATE REC'D. BY REGISTRAR SEP 18 1984 25b. REGISTRAR'S SIGNATURE <u>John Towson</u>	

Belmont County

U.S.A.

Belmont

G.P.O.C.

Belmont

Belmont County, Ohio

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Belmont County, Ohio

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Belmont County, Ohio

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23619

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9-13-84										2b. HOUR 12:35 P.M.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward FRANCIS Hilferty IV												2c. DATE PRONOUNCED DEAD 9-13-84	2d. HOUR 2:40 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 15 44	6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 9-13-84	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2029 Bear Ridge Road Apt. 204		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Underwriter		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE Maryland		13b. CITY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2029 Bear Ridge Rd. Apt 204		13f. ZIP CODE 21222			
14. FATHER'S NAME FIRST MIDDLE LAST Edward F. Hilferty III				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catharine L. Chandler									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Vietnam 215-42-1452		17. INFORMANT ADDRESS Thomas M. Hilferty 98 Morrison Lane Conowingo, MD 21918									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Chronic alcoholism													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE K.S. Ahluwalia				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 9/13/84					
EXAMINER'S NAME (TYPE OR PRINT) K.S. AHLUWALIA				ADDRESS 2112 Dundalk Av Balt. MD									
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 9/14/84		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				25a. DATE REC'D. BY REGISTRAR SEP 18 1984				25b. REGISTRAR'S SIGNATURE					
7922 Wise Avenue Dundalk, MD. 21222													

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23020

1. DECEASED NAME (TYPE OR PRINT) <b>Mr. William G. Hill</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>9 9 1984</b>		2b. HOUR M <b>4:15 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>29</b> YEAR <b>1900</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>84</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.
10. CITY OR TOWN OF DEATH <b>Woodlawn</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9501 Old Court Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sargeant-Balto.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>County Police</b>
13a. STATE <b>Maryland</b>	13b. CITY <b>Baltimore</b>	13c. CITY OR TOWN <b>Woodlawn</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>9501 Old Court Road</b> <b>21207</b>
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>Hill</b> LAST <b>Hill</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Elizabeth</b> LAST <b>Reynolds Hill</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>WW 1</b>	17a. MR. AND MRS. JOSEPH CARBO <b>506 Woodbine Avenue</b>		17b. <b>21204 Towson Maryland</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) DUE TO, OR AS A CONSEQUENCE OF				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Stanley Felsenberg</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>9/11/84</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Stanley Felsenberg</b>		ADDRESS <b>11 East St. Chase Street</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>09-13-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Alphonsus Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodstock Baltimore MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Loring Byers</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 11 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Felia Davidson-Randall</b>

1. The purpose of this form is to provide a means for the recording of the results of the performance of the work assigned to the employee.

2. This form is to be completed by the supervisor of the employee being evaluated.

3. The supervisor should evaluate the employee's performance on the basis of the following factors:

- a. Quality of work
- b. Quantity of work
- c. Efficiency
- d. Initiative
- e. Cooperation
- f. Attendance
- g. Conduct

4. The supervisor should evaluate the employee's performance on a scale of 1 to 5, with 1 being the lowest and 5 being the highest.

5. The supervisor should provide a written evaluation of the employee's performance, including a description of the employee's strengths and weaknesses, and a recommendation for the employee's future performance.

6. The supervisor should sign and date the evaluation, and submit it to the appropriate authority for review and approval.

7. The employee should be given a copy of the evaluation, and should be given an opportunity to discuss the evaluation with the supervisor.

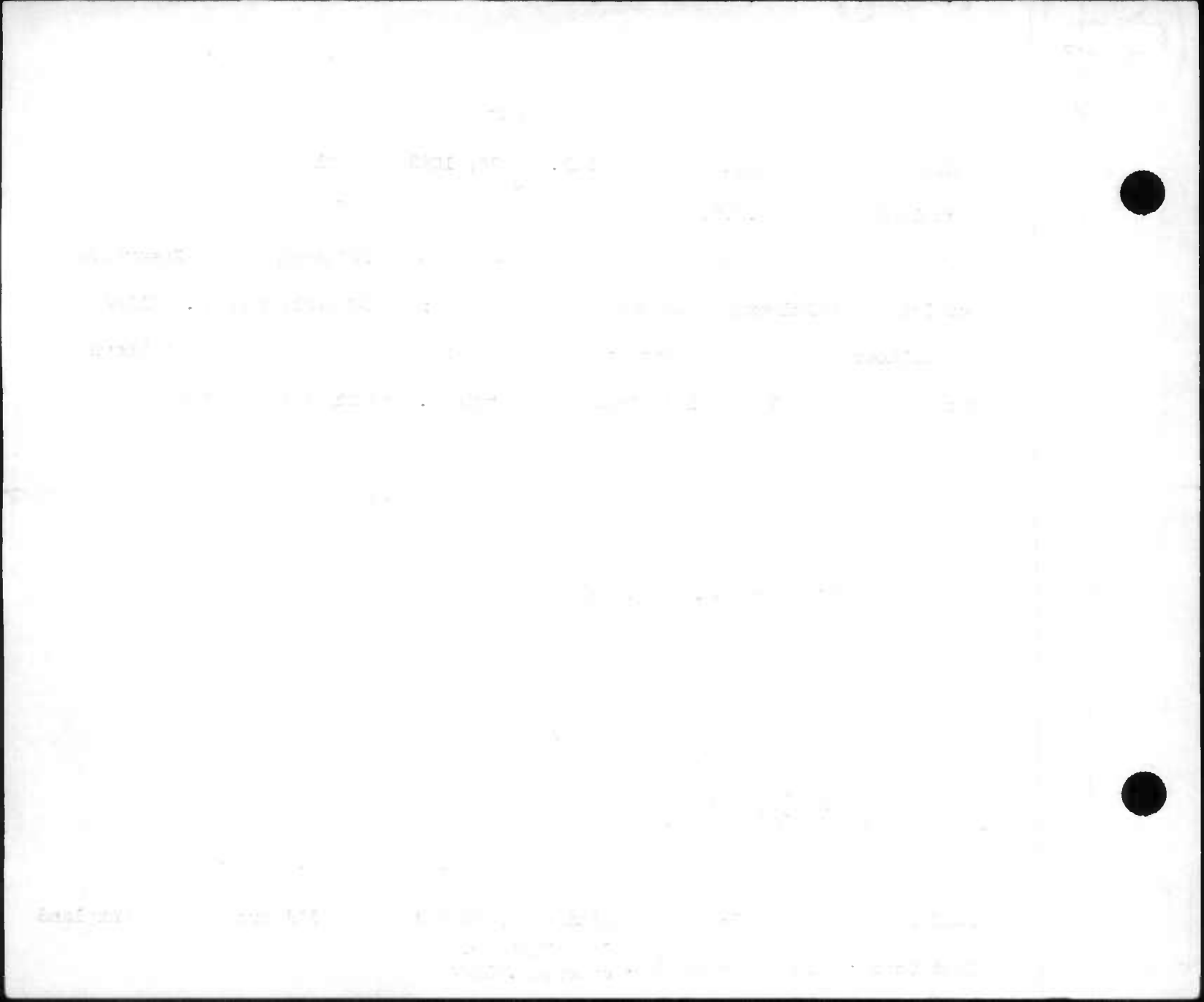
8. The evaluation should be used as a basis for the employee's performance appraisal, and should be used to determine the employee's eligibility for promotion, salary increase, and other benefits.

9. The evaluation should be kept on file for a period of one year, and should be available for review by the employee and the appropriate authority.

10. The evaluation should be used as a basis for the employee's performance appraisal, and should be used to determine the employee's eligibility for promotion, salary increase, and other benefits.

## MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 4 2 3 6 2 2	
1. DECEASED NAME (TYPE OR PRINT) <b>Desdemona G. Holloway</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>9-29-84</b>		2b. HOUR <b>10 45 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 - 3 - 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balt. Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE RUXTON</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>319 Quaker Ridge Rd. 21093</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gaylord Biggs</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Gent</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-54-6764</b>		17. INFORMANT ADDRESS <b>319 Quaker Ridge Rd. Monterey Burton, Timonium, MD 21093</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cerebrovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME		21e. PLACE OF INJURY (42 HOURS STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <b>Nov 82</b> to <b>29 Sept 84</b> , that (1) (we) lost <b>0</b> and that in my (our) opinion death occurred on the date and hour and from the cause stated											
22b. SIGNATURE <b>Marc I. Leavey MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>30 Sept 84</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARC I. LEAVEY MD</b>				22e. ADDRESS <b>7600 Osler Drive, Towson MD 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Sept. 30, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cratin &amp; Ferris</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>West Chester, Chester, PA</b>					
24. FUNERAL DIRECTOR NAME <b>J. J. Hartenstein, New Freedom, PA 17349</b>				25a. DATE REC'D. BY REGISTRAR <b>Oct 3</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henry Windus Hoppe			2a. DATE OF DEATH MONTH DAY YEAR September 2, 1984		2b. HOUR PM 11:50
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 21 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Glen Arm	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10812 Harford Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician		12b. KIND OF BUSINESS OR INDUSTRY Electronics
13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Glen Arm	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Werner Hoppe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Purdy		13e. STREET ADDRESS / ZIP CODE 10812 Harford Rd. 21057	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-09-5770		17. INFORMANT ADDRESS Ruth N. Hoppe same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ischemic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>11/16</u> , 19 <u>83</u> , to <u>present</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive <u>above</u> , (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>R. Weber</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/4/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Weber		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 9/6/1984	23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz III		ADDRESS Jarrettsville, Md.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death certificate. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Robert Leroy Horton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 24, 1984</b>		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 24, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Essex</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>31 Bret Court</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Essex</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>31 Bret Ct. Balto. 21221</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Isaac Horton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Henry</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>215-10-7790</b>		17. INFORMANT <b>Barbara L. Watson Elkridge, Maryland 21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>under</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>under</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>hypertension</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>under</b>
19a. DATE OF OPERATION <b>N.A.</b>					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N.A.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>N.A.</b>		21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR <b>N.A.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>N.A.</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>N.A.</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N.A.</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N.A.</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1984</b> to <b>Sept. 20, 1984</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>Sept. 20, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dionisid Garcia, Jr.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/26/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dionisid Garcia, Jr.</b>		22e. ADDRESS <b>413 Eastern Ave. Baltimore, MD. 21221</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/27/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Vet. Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville AA. Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Kaufman Funeral Home Elkridge, Maryland 21227</b>		25. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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12. *Utricularia*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

6 4 2 3 6 2 5

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph E Humberson</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9 17 84</b>		2b. HOUR <b>7:50 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 28 02</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81 YRS.</b>	
10. CITY OR TOWN OF DEATH <b>Balto Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Marion Care Nurs. Home</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County MD.</b>	
13a. STATE <b>md.</b>		13b. COUNTY <b>Balto.</b>		13c. STREET ADDRESS / ZIP CODE <b>109 N. Port Street 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ELLSWORTH HUMBerson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLA SNYDER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Steel worker</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>217-03-9246</b>		17. INFORMANT ADDRESS <b>SOPHIA HUMBERSON 109 N. Port St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>AICVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>Cerebrovascular disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>9.1.84</b> , to <b>9.17.84</b> , that (1) (we) lost saw the deceased alive on <b>9.1.84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. Haroun</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9.18.84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. HAROUN</b>		22e. ADDRESS <b>108 S. Taylor Ave., Balto., MD 21221</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>9/21/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART JESUS BALTIMORE MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Raymond H. Kaczorowski</b>		ADDRESS <b>2525 Fleet St.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>	

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 23620							
1 DECEASED NAME (TYPE OR PRINT) <u>Daisy H. Humphreys</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>9-3-84</u>			2b. HOUR <u>10:25 AM</u>	
3. SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>May 18, 1890</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>94</u>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Louisiana</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Balto County</u> MD.			
10 CITY OR TOWN OF DEATH <u>Towson</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>MANOR CARE - Ruxton</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13a STATE <u>Maryland</u>		13b COUNTY <u>Baltimore</u>		13c CITY OR TOWN <u>21204</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <u>21204</u> <u>205 E. Joppa Rd. #905</u>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>John Hirtzler</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Hannah McGlaughlin</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO. <u>212-32-4467</u>		17 INFORMANT ADDRESS <u>Mildred H. Cosgrove 21204</u> <u>205 E. Joppa Rd #905</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 mm</u> <u>YEARS</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Fractured Hip</u>									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (a) this hospital attended the deceased from <u>July 8/3</u> , 19 <u>84</u> to <u>Sept 9</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8/3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Richard W. Bittrick MD</u>								22c. DATE SIGNED <u>9/3/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RICHARD W. BITTRICK</u>								22e ADDRESS <u>8100 HARBOR ROAD 21234</u>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>Sept. 4, '84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GreenMount Cemetery</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>			
24 FUNERAL DIRECTOR NAME ADDRESS <u>William E. Johnson 8521 Loch Raven Blvd.</u>						25a DATE REC'D. BY REGISTRAR <u>SEP 4 1984</u>			
25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>									

BP

RECEIVED  
JAN 10 1960

10-1

TO: Mr. J. Edgar Hoover  
FROM: Mr. [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

[illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be assigned within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

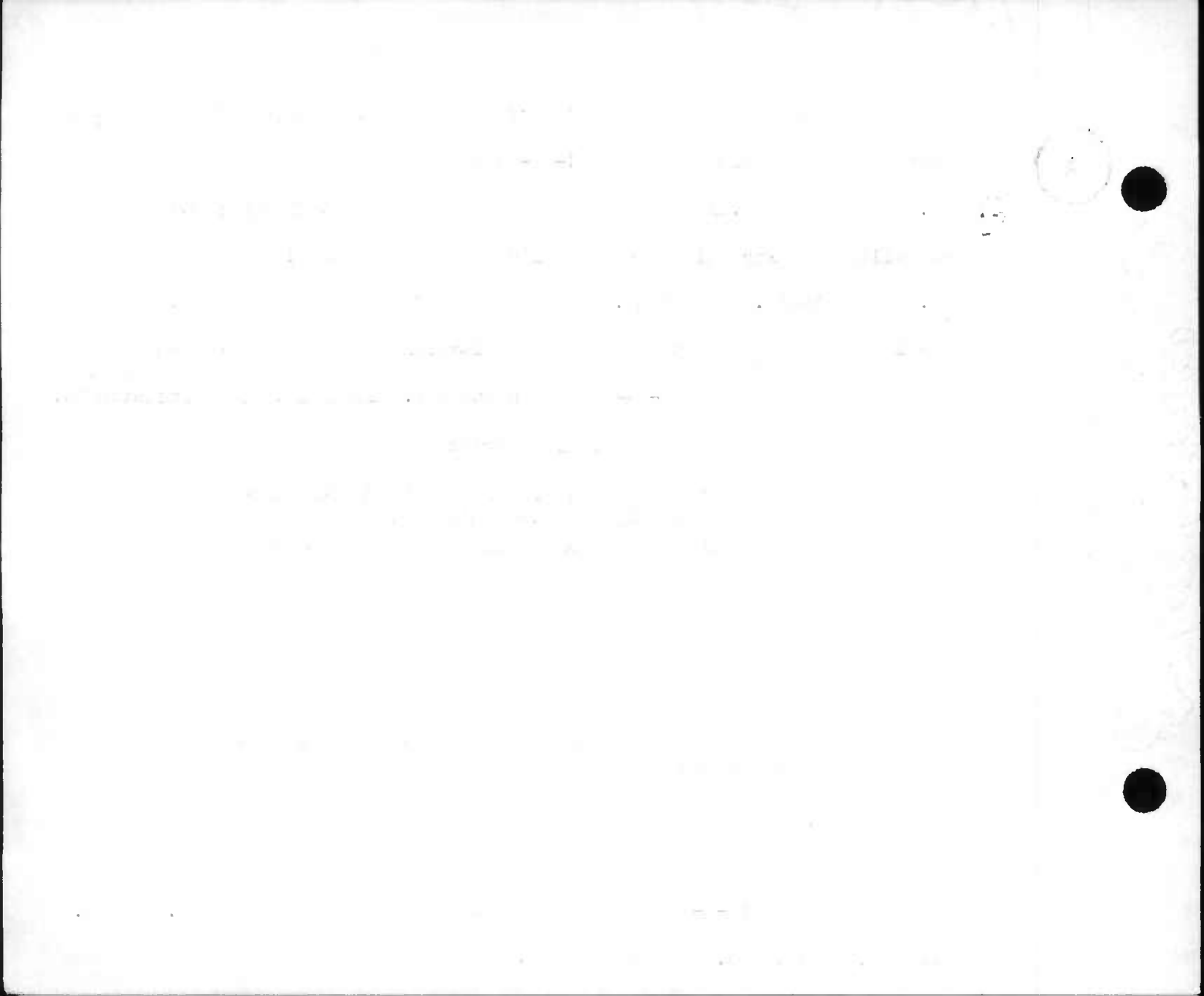
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of one.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
Neva L ISENNOCK		Female		White	
5a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		5b CITIZEN OF WHAT COUNTRY?		5c DATE OF BIRTH MONTH DAY YEAR	
Md.		U.S.A		1-29-1898	
6 CITY OR TOWN OF DEATH		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	
Rossville		Md.		U.S.A	
8 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH		10a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Franklin Square Hospital		Baltimore County MD.		Housewife	
11 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12a STREET ADDRESS / ZIP CODE		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE 13b COUNTY 13c CITY OR TOWN		9803 Harford Rd. 21234			
13a STATE 13b COUNTY 13c CITY OR TOWN		9803 Harford Rd. 21234			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Levi Campbell		Elizabeth Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS	
No		212-74-4600		Margaret V. Gillespie, 2301B Tarleton La. 21234	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(a) Cardio pulmonary arrest					
(b) Malnutrition, abdominal surgery status post pulmonary embolism, hip fracture					
(c) Cerebrovascular accident, pneumo thorax					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from August 28, 1984, to September 29, 1984, that (I) (we) last saw the deceased alive on September 29, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE		22c DATE SIGNED	
Dr. Jagiello		DEGREE		9/29/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Jagiello		9000 Franklin Square Dr 21237			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		10-3-84		Fork Methodist	
23d LOCATION CITY OR TOWN COUNTY STATE		23e DATE REC'D. BY REGISTRAR		23f REGISTRAR'S SIGNATURE	
Fork Balto. Md.		OCT 1 1984		Julia Davidson Anderson	
24 FUNERAL DIRECTOR NAME ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc., 5305 Harford Rd.		OCT 1 1984		Julia Davidson Anderson	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jesse Berkley Jacobs, Jr.			2a. DATE OF DEATH MONTH DAY YEAR Sept. 23, 1984		2b. HOUR 11:55 A M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 9 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Riderwood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1708 Willow Ave., 21204				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool & Die Maker		12b. KIND OF BUSINESS OR INDUSTRY Bendix Electronics			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Riderwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1708 Willow Ave., 21204			
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Berkley Jacobs, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Mundie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT 219-01-3656		ADDRESS Loretta R. Jacobs, 1708 Willow Ave., 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 19 90 to 9. 23, 1984, that (I) (we) lost saw the deceased alive on 9. 23, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Keith A. Manley			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9. 21. 84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith A. Manley, M. D.			22e. ADDRESS 1818 Pot Spring Rd., Timonium, Md. 21093								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/27/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Balto. Md.				
24. FUNERAL DIRECTOR NAME Martin D. Lawson			25a. DATE REC'D. BY REGISTRAR OCT 1 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 6 2 9

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>G. Melva Jachelski</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-30-84</b>			2b. HOUR <b>8:45 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-20-20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pittsburg, Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Beautician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Parlor</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1104 Cooks Lane -21229</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Begly</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Schwab</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
17a. SOCIAL SECURITY NO. <b>174-12-9052</b>		17. INFORMANT <b>Mrs. Sara M. Begly-131 Deep Run Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung C.A.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9:30 89 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9:30 89</b> to <b>9:30 89</b> , that (I) (we) last saw the deceased alive on <b>9:30 89</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Rayadurg G. G. Rao</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAYADURG G. G. RAO</b>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/4/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn-Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Sterling Funeral Estate, P. A.</b>		ADDRESS <b>736 Edmondson Avenue-Catonsville, Md. 21228</b>		25a. DATE REC'D. BY REGISTRAR <b>5 1984</b>		25b. REGISTRAR'S SIGNATURE <b>William W. Anderson</b>	

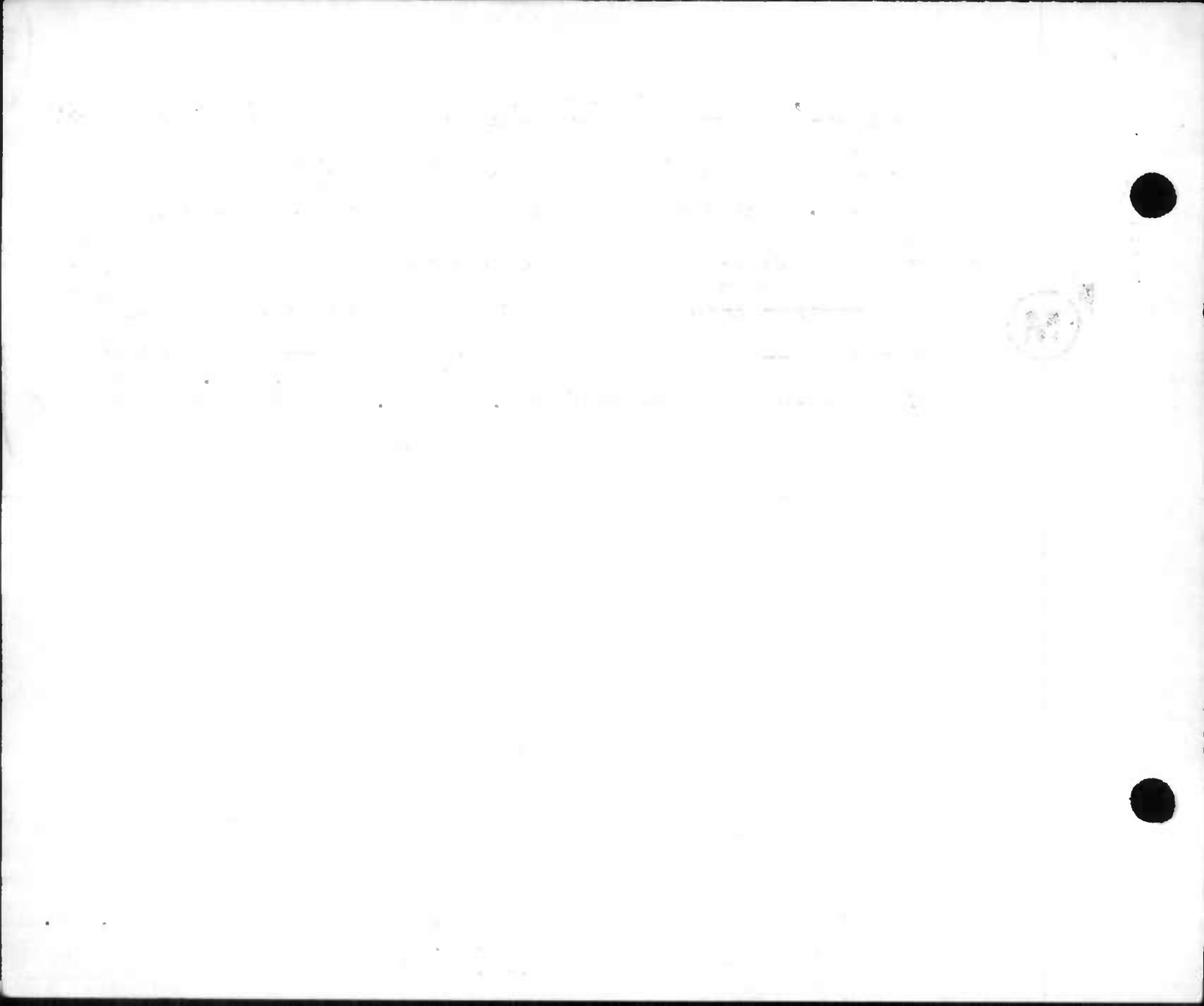
MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon adapters. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is checked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



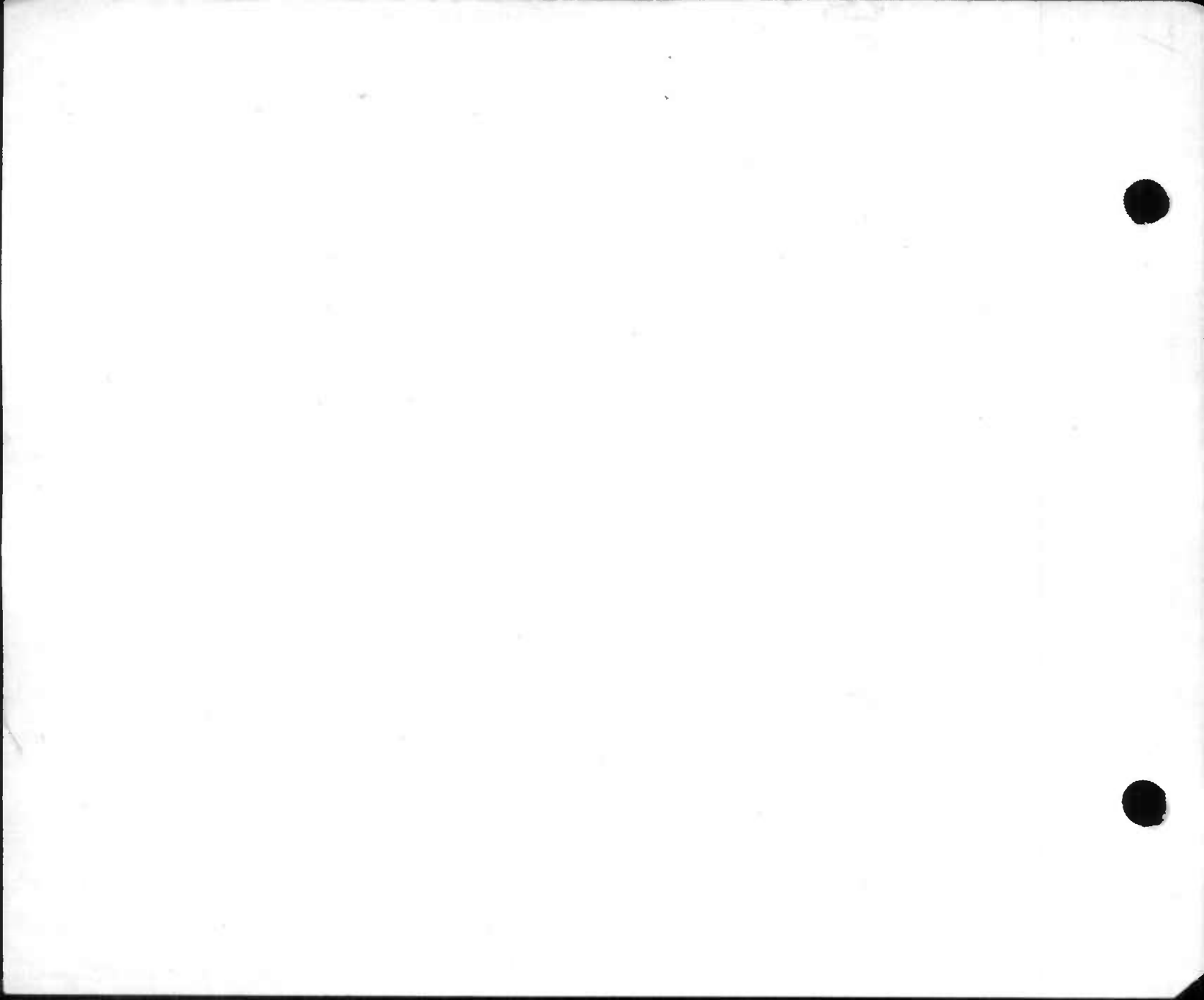


TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 23630							
1 DECEASED NAME (TYPE OR PRINT) Frank Jankiewicz					2a DATE OF DEATH MONTH DAY YEAR 9-7-84			2b HOUR 3:05 AM	
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 12 10 8		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrison Valley Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD		13b COUNTY 13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 630 W. Fayette St. 21201			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Jankiewicz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Szymanski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 718-18-0303		17 INFORMANT ADDRESS Cobb Island, Md. James W. Jenkins, Sr. P.O. Box 26 20625					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE Many years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypothyroidism									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 2-23-19-84 to 9-7-19-84, that (I) (we) last saw the deceased alive on 9-7-19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Smith an				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 9-7-84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) 1528 KING WILLIAM DRIVE, Balto. MD SHAWKAT Y. KHAN				22e ADDRESS 1528 KING WILLIAM DRIVE, Balto. MD 21228					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 9/11/84		23c NAME OF CEMETERY OR CREMATORY Holy Rosary Cem		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24 FUNERAL DIRECTOR NAME Wm C March F/H Inc.				ADDRESS 1101 E North Ave		25a DATE REC'D. BY REGISTRAR SEP 13 1984		25b REGISTRAR'S SIGNATURE Julia Davidson-Randell	



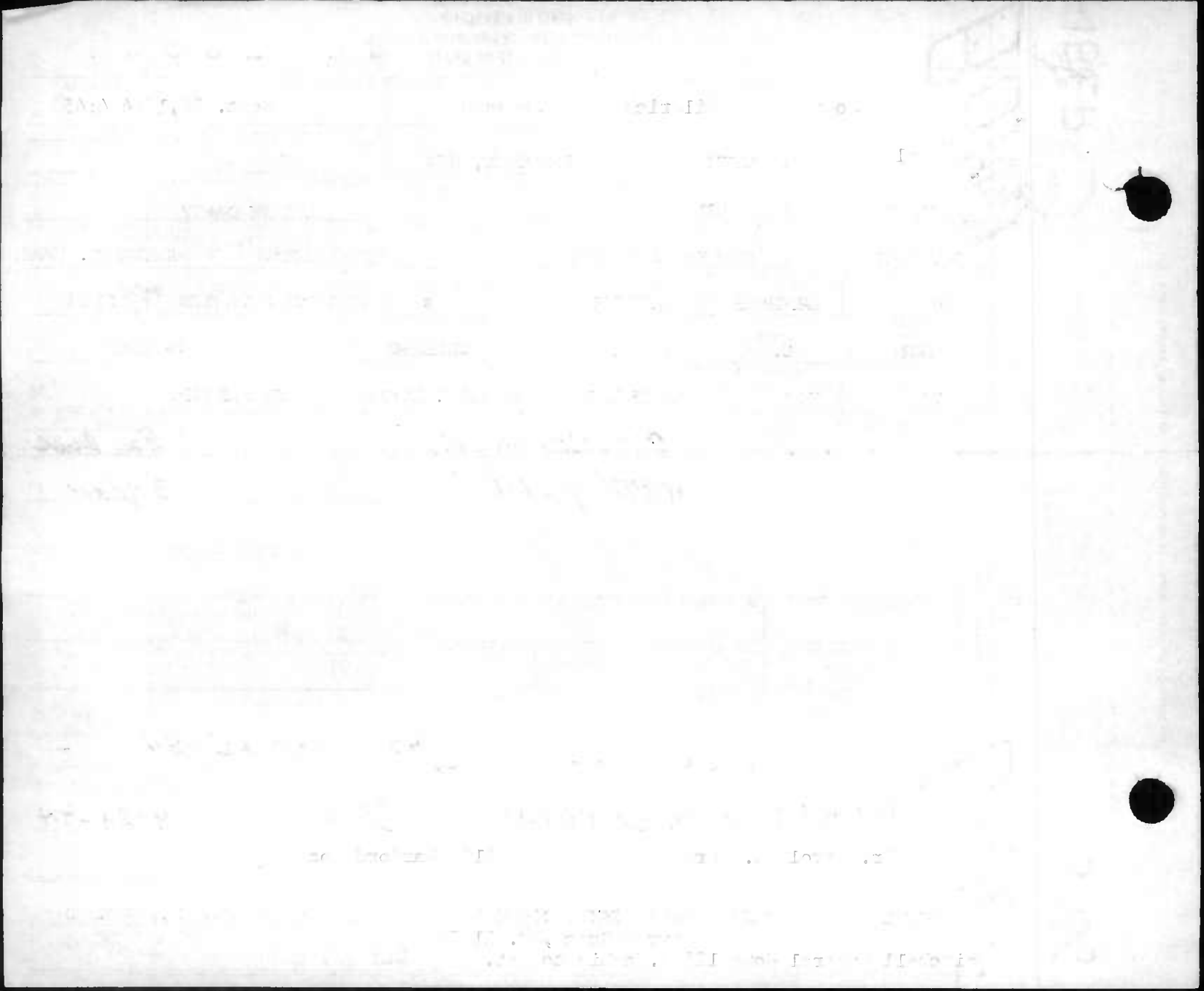
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 6 4 2 3 6 3 1							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Hildrich Janssen						2a. DATE OF DEATH MONTH DAY YEAR Sept. 23, 1984		7b. HOUR 4:45P M	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 22, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2700 EAST JOPPA ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) WIREMAN		12b. KIND OF BUSINESS OR INDUSTRY UTILITY CO. (BG&E)	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2700 EAST JOPPA ROAD 21234	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN U. JANSSEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE MAGSAMEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 212 05 4803		17. INFORMANT ADDRESS ROBERT W. JANSSEN SAME AS #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest,</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old age</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>47</u> to <u>Sept 22</u> 19 <u>84</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>9-22</u> 19 <u>84</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Harold H. Burns</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-24-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Harold H. Burns				22e. ADDRESS 8106 Harford Road					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 26 SEPTEMBER 84		23c. NAME OF CEMETERY OR CREMATORY BAKERS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ABERDEEN, HARFORD CO., MARYLAND			
24. FUNERAL DIRECTOR NAME Mitchell Funeral Home				ADDRESS HavreDeGrace, Md. 21078 123 S. Washington St.		25a. DATE REC'D. BY REGISTRAR SEP 27 1984		25b. REGISTRAR'S SIGNATURE <u>He Davidson-Randall</u>	

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 23632			
1. DECEASED NAME (TYPE OR PRINT) <b>George A.W. Jansson, Jr.</b>												2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> 9 9 1984		2b. HOUR <b>AM</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Apr. 16th, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>19</b>		2d. HOUR <b>M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Conn.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rodgers Forge, Balto. Co.</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. Co. Park - 6400 York Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Probation Officer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't.</b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto. Co.</b>				13c. CITY OR TOWN <b>Rodgers Forge</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS <b>327 Dunkirk Rd. 21212</b>				14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Geo. A.W. Jansson, Sr.</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Mary C. Anderson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes.</b>				16b. SOCIAL SECURITY NO. <b>WW-2 213-14-5705</b>				17. INFORMANT ADDRESS <b>Mrs. Patricia C. Jansson-327 Dunkirk Rd-12</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of chest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR) <b>9 9 1984</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Self-inflicted GSW</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY FARM, ETC.) <b>Park</b>				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <b>6400 York Rd. Baltimore Balto 21212</b>							
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>R. Breiteneker</b>				TITLE (SPECIFY) <b>Dep.</b>				MEDICAL EXAMINER				DATE SIGNED <b>9/9/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>R. BREITENECKER</b>				ADDRESS <b>GBHC</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Body Donation</b>				23b. DATE <b>9/9/84</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Bd. of Md.</b>				23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>Balto Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 York Rd. 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 6 3 3

1- FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)FIRST MIDDLE LAST  
EUGENE F. JENDREK Sr.

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR

SEPTEMBER 21, 1984 6:25 AM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
2-14-14

6. AGE (IN YEARS LAST BIRTHDAY)

70

7. IF UNDER 1 YEAR

IF UNDER 24 HRS  
MONTHS DAYS HOURS MIN.

8. BIRTHPLACE (STATE OR FOREIGN)

Balto. Md.

9. CITIZEN OF WHAT COUNTRY?

U.S.A.

10. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

11. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY, MD

12. CITY OR TOWN OF DEATH

Towson

13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

ST. JOSEPH HOSPITAL

14. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Accountant-Retired Union Trust

15. KIND OF BUSINESS OR INDUSTRY

16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

17a. STATE

Md.

17b. COUNTY

Balto.

17c. CITY OR TOWN

Balto.

18. INSIDE CITY LIMITS?

YES ☐ NO ☒

19. STREET ADDRESS / ZIP CODE

4507 Fullerton Ave. - 21236

20. FATHER'S NAME

FIRST MIDDLE LAST  
Eugene F. Jendrek

21. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Marie Ganzhorn22a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

Yes

22b. SOCIAL SECURITY NO.

111 Army

22c. SOCIAL SECURITY NO.

217-09-6957

23. INFORMANT

Mr. Michael J. Jendrek - Balto. Md. - 21236

24. ADDRESS

4507 Fullerton Ave.

25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Multiple Myeloma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 Mo

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

26a. DATE OF OPERATION

26b. CONDITION FOR WHICH OPERATION WAS PERFORMED

27a. AUTOPSY?

YES ☐ NO ☐28a. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐29a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)29b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

30a. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK30b. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

30c. LOCATION

STREET CITY OR TOWN COUNTY STATE

31. I certify that (I) (this hospital) attended the deceased from 9/13, 19 84, to 9/21, 19 84, that (I) (we) lost  
saw the deceased alive on 9/21, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

32a. SIGNATURE

Arthur A. Serpelle

32b. DEGREE

MD

32c. ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

33. DATE SIGNED

9/21/84

34. PHYSICIAN'S NAME (TYPE OR PRINT)

Arthur A. Serpelle

35. ADDRESS

Saint Joseph Hosp Towson MD

36a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

36b. DATE

9-24-84

36c. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

36d. LOCATION  
CITY OR TOWN

Balto. Md.

COUNTY STATE

37. FUNERAL DIRECTOR

NAME ADDRESS  
John C. Miller Inc-6415 Belair Rd. - 21206

38a. DATE REC'D. BY REGISTRAR

SEP 24 1984

38b. REGISTRAR'S SIGNATURE

San Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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217-00-697



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

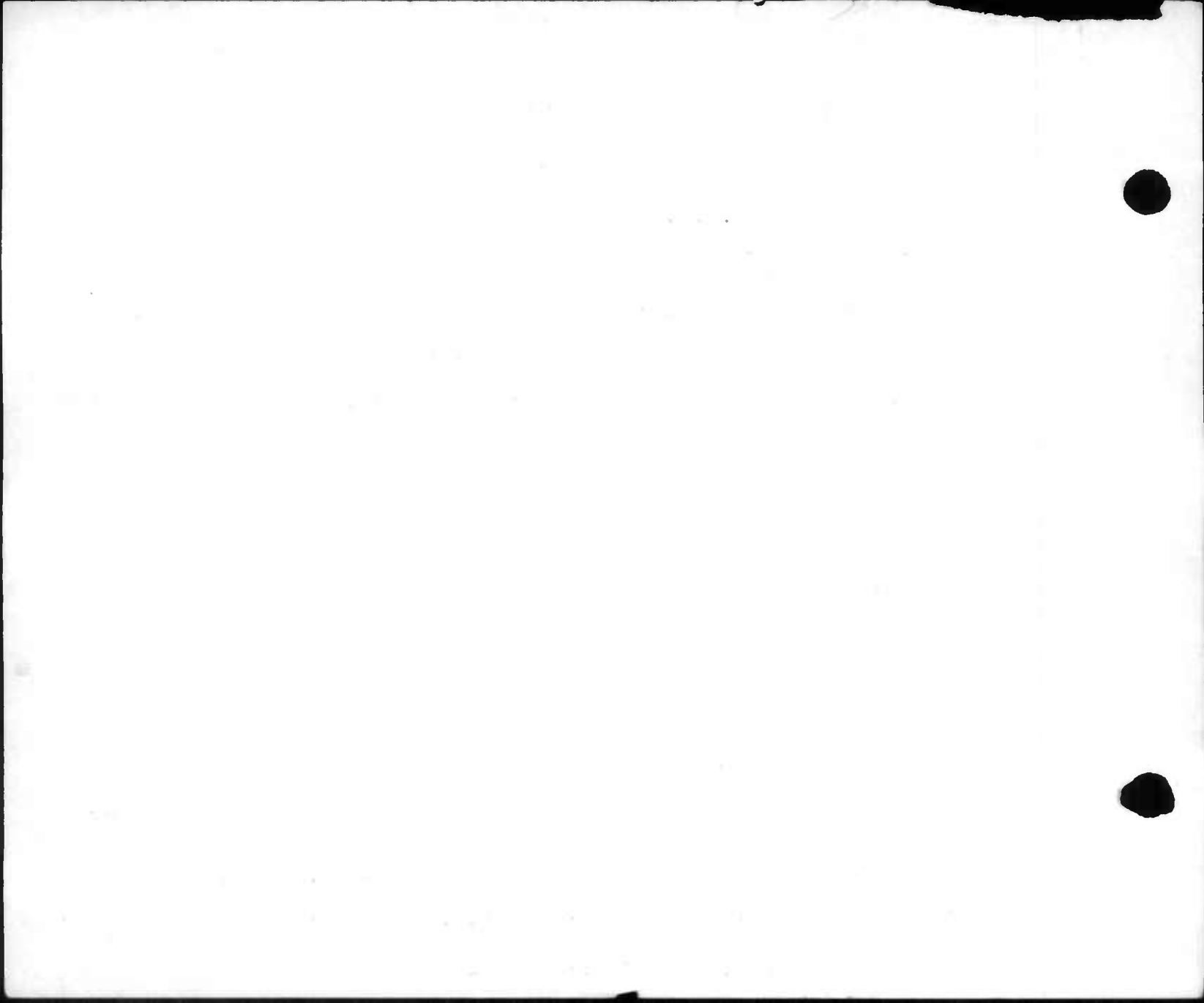
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IRMA A. JENKINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 06 '84</b>		2b. HOUR <b>11:45 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 9 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD</b>		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>601 Wyanoke Avenue 21218</b>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Stevenson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>UNKNOWN</b>		16b. SOCIAL SECURITY NO. <b>216-24-2421</b>		17. INFORMANT ADDRESS <b>Elaine Matthews 1306 Kitmore Road</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>SEIZURE DISORDER, STROKE</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/31</b> 19 <b>84</b> to <b>9/6</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Jay M. Lustbader, MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/6/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAY M. LUSTBADER, M.D.</b>				22e. ADDRESS <b>GBMC - 6701 N. CHARLES ST. 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>9/10/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1984</b>		
				25b. REGISTRAR'S SIGNATURE <i>Ra Davidson-Randall</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

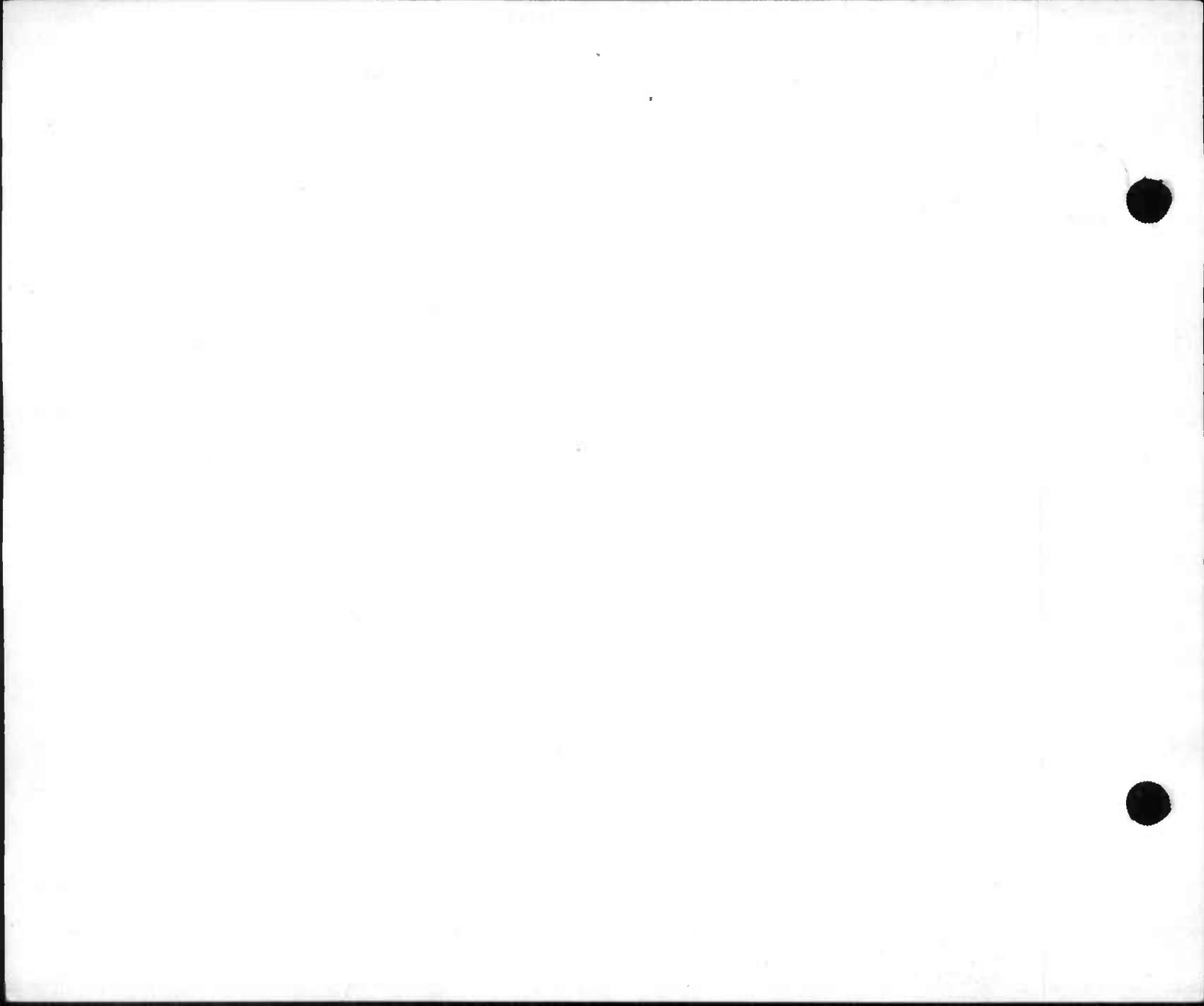
REG. NO. 2 3 6 3 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Cecilia Johnson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 7 84</i>		2b. HOUR M <i>M</i>						
3. SEX <i>F</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 14 01</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>83</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>83</i>		8. IF UNDER 24 HRS HOURS MIN <i>83</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S. CAROLINA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. County MD.</i>					
10. CITY OR TOWN OF DEATH <i>Garrison Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Garrison Valley Nursing Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Garrison</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>9600 Reisterstown Rd. 21055</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Williams</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cecilia</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <i>241386696A</i>			
17. INFORMANT		ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ventricular Arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>A CHD</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>IMMEDIATE</i> <i>Many years</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>8 9-7-84</i> to <i>9-7-84</i> , that (I) (we) last saw the deceased alive on <i>9-7-84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Shaukat Y. Khan</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>9-7-84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SHAUKAT Y. KHAN</i>				22e. ADDRESS <i>1528 KING WILLIAM DRIVE, Balto, MD</i>							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE <i>9-11-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Maryland</i>		23e. DATE REC'D. BY REGISTRAR <i>11 1984</i>			
24. FUNERAL DIRECTOR NAME <i>IRVIN CARROLL</i>		ADDRESS <i>17214 W. NORTH AVE</i>		25a. DATE REC'D. BY REGISTRAR <i>11 1984</i>				25b. REGISTRAR'S SIGNATURE <i>William J. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Corinne Dorsey Johnson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 28 1984</b>		2b. HOUR <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 29 1919</b>		6. AGE (IN YEARS, LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Monkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>17441 Troyer Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher (Retired)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Monkton</b>	13c. CITY OR TOWN <b>Monkton</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Dorsey</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary L. Hicks</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>216-20-1402</b>		17. INFORMANT <b>Woodrow Johnson</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Breast Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a.					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/6</u> 19 <u>83</u> , to <u>9/28</u> 19 <u>84</u> , that (I) (we) lost <u>the deceased alive</u> <u>above</u> , (I) (we) (did) (did not) <u>show the body after death</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <i>Dain M. Loh</i>		DEGREE <i>mb</i>		22c. DATE SIGNED <i>10/1/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/2/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel U. M.</b>	
23d. LOCATION CITY OR TOWN <b>Monkton, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>		23f. REGISTRAR'S SIGNATURE <i>J. Davidson</i>	
24. FUNERAL HOME OR OTHER PLACE OF INTERMENT NAME ADDRESS <b>Nutter &amp; Sons 2501 Gwynns Falls Parkway Funeral Home Inc. Baltimore, Maryland 21216</b>					

BP

Continne	Barrett	Johnson
17441	17441	17441
U. S. A.	X	
Monkton	17441 Proyer Road	
Monkton	Monkton	X
Arthur	Borrey	Monkton, Maryland 21111
No.	215-20-1402	17441 Proyer Road
		Monkton, Maryland 21111
		Monkton, Maryland 21111
		Monkton, Maryland 21111

General Home Inc. Baltimore, Maryland 21210  
 2501 Gwynne Ave. Baltimore  
 801-1100  
 Union City, N. J.  
 Monkton, Maryland

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

4 2 3 6 3 1

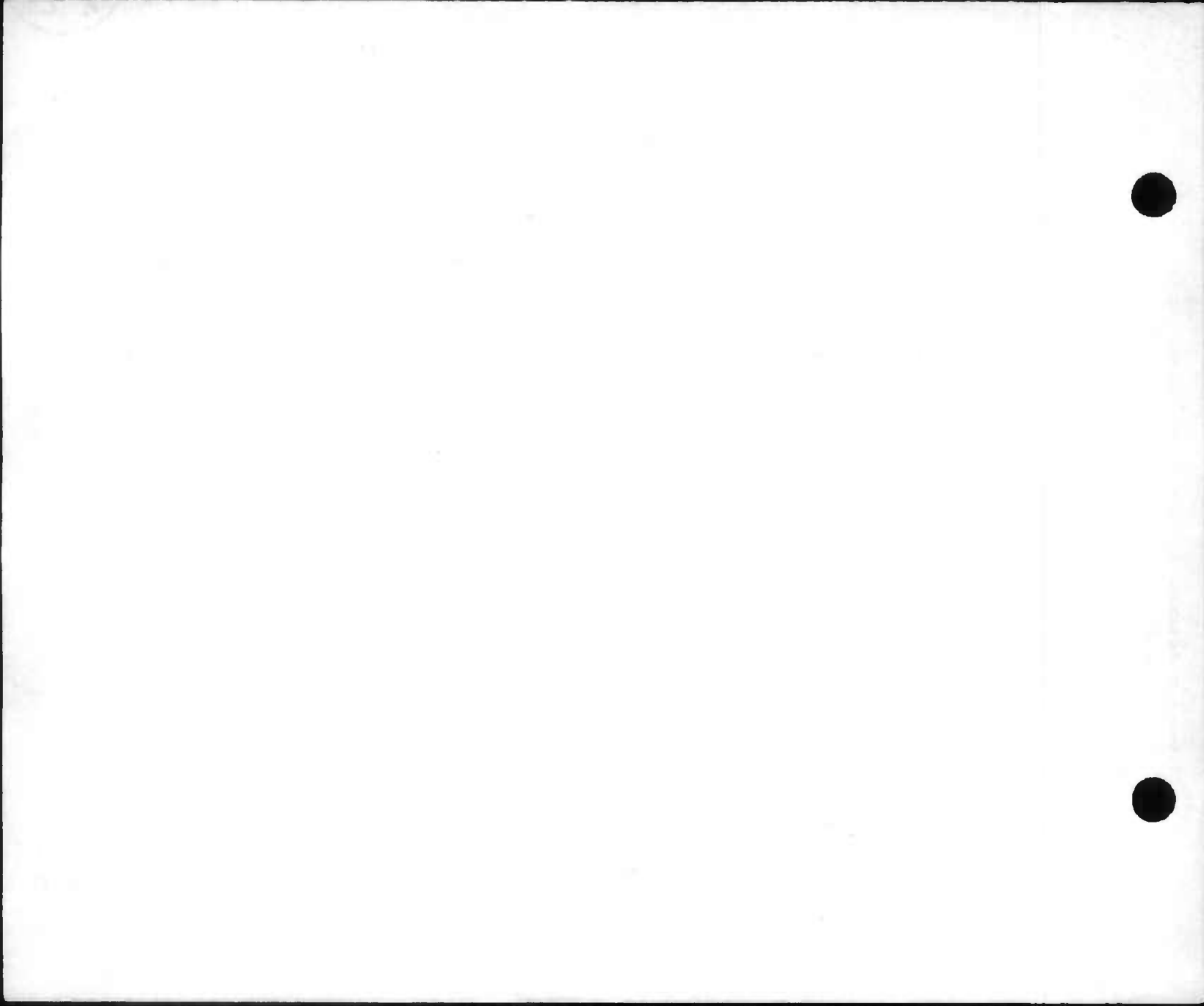
1. DECEASED NAME (TYPE OR PRINT) <b>Lydia GLATZEL Johnson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-28-84</b>			2b. HOUR <b>11:00</b> M			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 24 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD -</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS Hospice</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>md</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>SANFORD AVE 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AUGUST</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET Kähler</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>LOIS M. Young</b>		ADDRESS <b>405 DOVE LANE HANSTOWN</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/1</b> , 19 <b>83</b> , to <b>9/28</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/23</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. Faulkner MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>9/28/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENDALL FAULKNER</b>				22e. ADDRESS <b>2300 DULANEY VALLEY RD Towson MD 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/1/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lochside Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>PRITTS F.W. WESTMINSTER</b>				ADDRESS <b>OCT 3 1984</b>		DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rodell</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

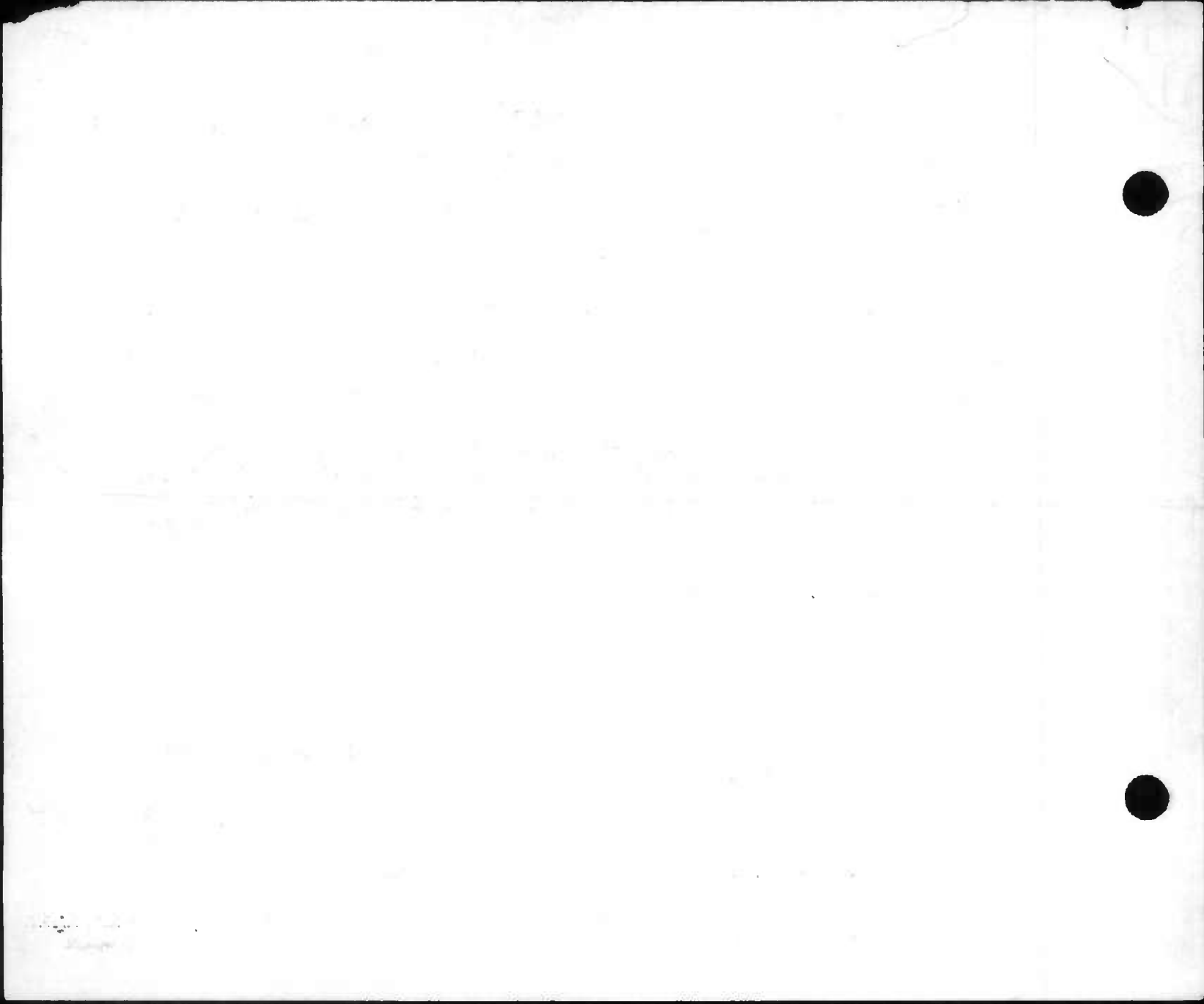
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23638

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR MIN.	
Mabel D JONES		September 16, 1984		4:38 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	73 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Rossville	Franklin Square Hospital		Housewife		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4508 Powell Avenue 21206	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
FIRST MIDDLE LAST	FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.		
Emmett Adams	Mary Hester Powers		223-10-6551		
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
Edsel C. Davis		PART 1. DEATH WAS CAUSED BY:			
Same as 13e		IMMEDIATE CAUSE (a) Cardiac arrest, cardioseptic shock, myocardial infarction with left bundle branch block, renal failure			
		(b) Arteriosclerotic heart disease, generalized arteriosclerosis			
		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Diabetes Mellitus					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from September 2, 1984, to September 16, 1984, that (I) (we) last saw the deceased alive on September 16, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
N. Okun, M.D.				9/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
N. Okun M.D.		9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY	STATE
Burial	9/19/1984	West End Cemetery	Wytheville		Virginia
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222		SEP 18 1984			

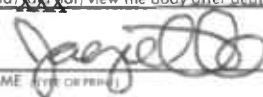
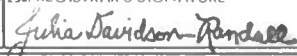
BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

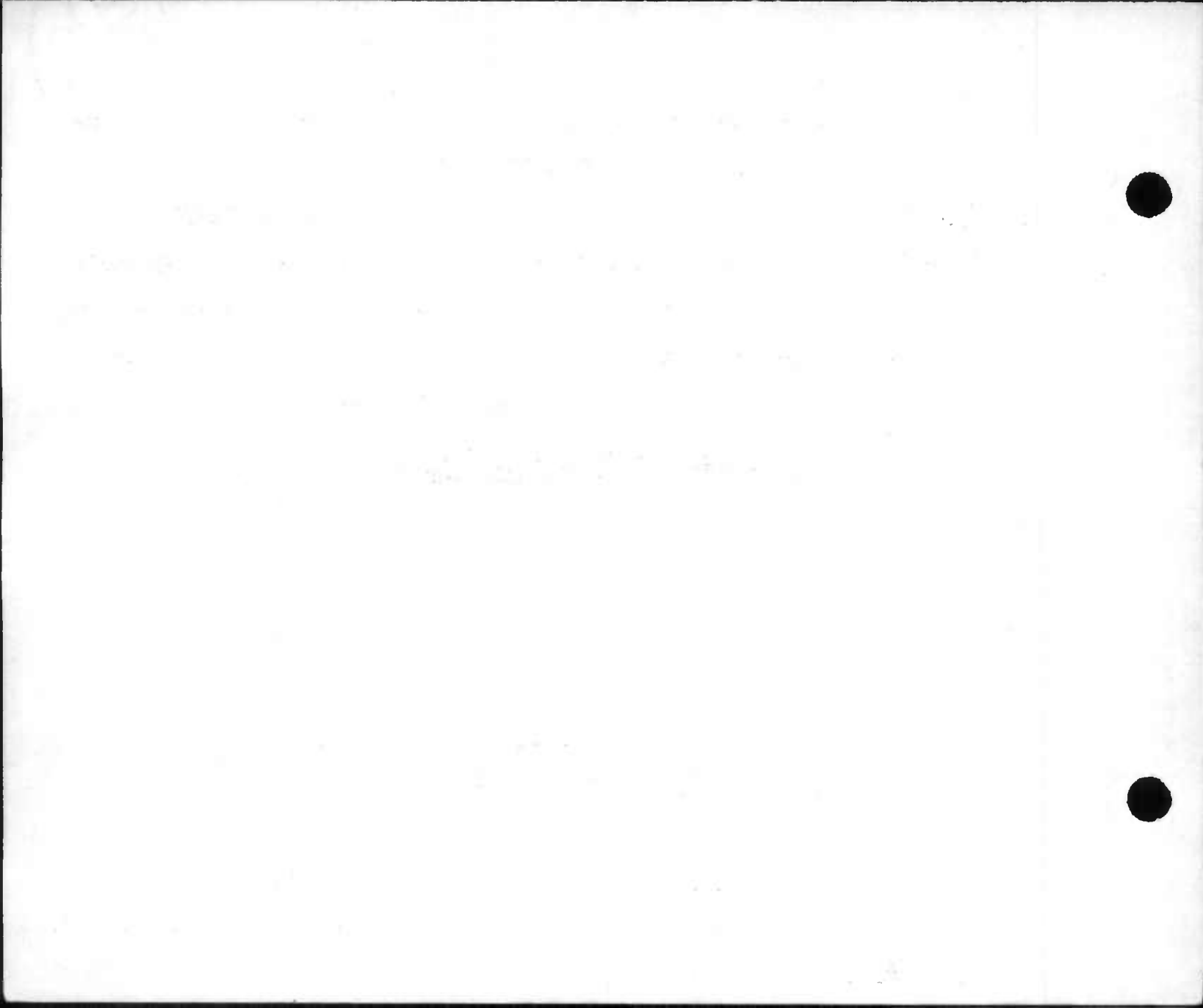
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM MCKINLEY JONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 30, 1984</b>		2b. HOUR <b>6:54 A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 11, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Bradshaw, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Rossville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Joppa</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jerimah Profit Jones</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura -- Brown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>710-09-6574-A</b>		17. INFORMANT ADDRESS <b>Joppa, Md. 21085</b> <b>Mrs. Lucille Jones, 302 Philadelphia Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY FAILURE</b> <b>STATUS POST WHIPPLE PROCEDURE for ADENOCARCINOMA of DUODENUM</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 26 19 84</b> to <b>SEPTEMBER 30 19 84</b> that (I) (we) last saw the deceased alive on <b>SEPTEMBER 30 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. <b>X</b>					
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BEN JAGIELLO M.D.</b>		22e. ADDRESS <b>9000 FRANKLIN SQUARE DRIVE 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Oct. 4, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Asbury U. Methodist Cemetery, Loreley Balto. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III, Abingdon, Md. 21009</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 2 1984</b>		25b. REGISTRAR'S SIGNATURE 	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3-B, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23640  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
MURLAN CERAL JORDAN			9 5 1984			2215		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	7c. DATE PRONOUNCED DEAD	7d. HOUR		
Male	White	9 6 1913	70 YRS.		9 5 1984	2345		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Kentucky		U.S.A.				Baltimore County MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Dundalk		1725 Rita Road		Esskay-Packing Co.		Employee		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Maryland			Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1725 Rita Road 21222		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.			
James Jordan			Martha Vaughn		236-10-9022			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			236-10-9022		Gertrude S. Jordan Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic emphysema</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>J. Crossan O'Donovan</u>			M.D. <u>Deputy</u>			DATE SIGNED <u>9/5/84</u>		
EXAMINER'S NAME (TYPE OR PRINT) <u>J. CROSSAN O'DONOVAN</u>			ADDRESS <u>2112 Dundalk Ave., Balb., Md. 21222</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			9/8/1984		Meadowridge		Dorsey Howard Maryland	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Duda-Ruck, Inc.			7922 Wise Avenue Dundalk, MD. 21222			SEP 10 1984 <u>John Davidson-Randall</u>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										213641 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>ERNEST JOSEPH KAHLER</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>9 3 1984</b>	
3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>11 13 15 68</b> YRS.										2b. HOUR <b>2100</b> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 4 1984</b>	
10. CITY OR TOWN OF DEATH <b>Dundalk</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>275 St. Helena Avenue</b>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>G.M. Corp.</b>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>275 St. Helena Ave. 21222</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Kahler</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Cox</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b>										16b. SOCIAL SECURITY NO. <b>202-09-6756</b>	
17. INFORMANT <b>Josephine M. Kahler-Balto., MD. 21224</b>										ADDRESS <b>248 S. Highland Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute intracerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I-a: <b>Chronic emphysema, Chronic alcoholism</b>											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b> M.D. <b>Deputy</b> MEDICAL EXAMINER										DATE SIGNED <b>9/4/84</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b> ADDRESS <b>2112 Dundalk Ave, Balb, Md. 21222</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>9/7/1984</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>											
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>										25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>	

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2. 2. 4. 4.

7. 2. 3. 3.

RECEIVED





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 3 6 4 2 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>BESSIE GLENN KANYUCK</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 22 84</b>	
3. SEX <b>Female</b> 4. RACE <b>White</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>March 7, 1920</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>64 YRS.</b> 7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2b. HOUR <b>1800</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD <b>9 22 84</b> 2d. HOUR <b>1915</b>	
10. CITY OR TOWN OF DEATH <b>Dundalk</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7028 Dunhill Road</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleslady</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Clothing</b>											
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>7028 Dunhill Rd. 21222</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Donald Julian</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lona Stevens</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>216.03.6613</b> 17. INFORMANT ADDRESS <b>Raymond A. Kanyuck (Same as 13e)</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b> M.D. <b>Deputy</b> MEDICAL EXAMINER DATE SIGNED <b>9/22/84</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b> ADDRESS <b>2112 Dundalk Ave., Balb., Md. 21222</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>9/25/1984</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Harford Maryland</b>											
24. FUNERAL DIRECTOR NAME ADDRESS <b>Walter Brooks Bradley, Inc., Dundalk Md. 21222</b> 25a. DATE REC'D. BY REGISTRAR <b>SEP 25 1984</b> 25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>											

1923

1923

1923

1923



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
<div> <div>1 - FOR STATE REGISTRAR</div> <div>2 3 6 4 3</div> <div>REG. NO.</div> </div>													
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
GEORGIA M. KAPRAUN				9 - 1 - 84		4/30 PM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		CAUS.		January 15, 1893		91 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Baltimore County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Parkville		Perring Pkwy Nursing Home		Housewife									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2814 Christopher Ave. 21214					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Unknown				Cynthia				Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				217-07-4543		Mr. Joseph W. Kapraun, Jr. 4758 Homesdale Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Acute Myocardial Infarction													
DUE TO, OR AS A CONSEQUENCE OF (b) C.H.F.													
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED									
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET									
22a. I certify that (I) (this hospital) attended the deceased from 19 8-24 1984, to 19 8-24 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
[Signature]													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
PARRA				7122 HARFORD RD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		9-5-84		Parkwood		Baltimore, Maryland							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Md.				SEP 5 1984				[Signature]					

1924-25

1924

Halifax County

Housewife

201, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

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Mr. Joseph A. Haywood, Jr., 1924

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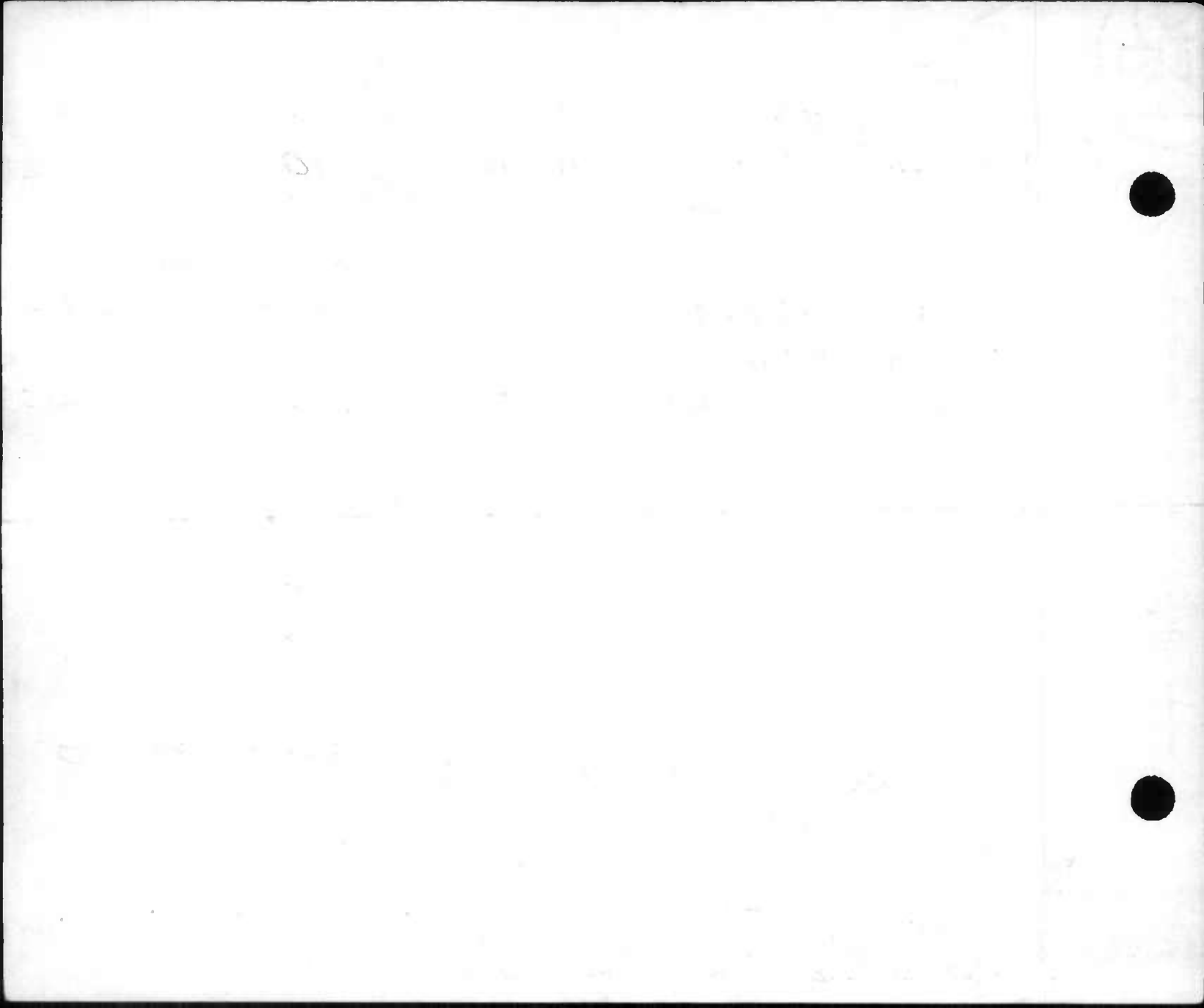
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23644	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CORDIA KARL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AUG 15 30, 1984</b>				2b. HOUR <b>4:50 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 16 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>SAINT JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTIMORE</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>6401 N CHARLES ST. 21212</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD PHILIP KARL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY KLARMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-54-3333</b>		17. INFORMANT ADDRESS <b>Sister Angelina 6401 N. CHARLES</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY EMBOLUS</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Gram positive sepsis ; spl cerebrovascular accident</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 30, 1984</b> to <b>AUG 30, 1984</b> , that (I) (we) last saw the deceased alive on <b>AUG 30, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Edward Wolf</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/30</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward Wolf</b>				22e. ADDRESS <b>6408 Elray Dr. Balt. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-3-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Villa Maria cem.</b>		23d. LOCATION <b>Glen Arm, Balt. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>CURRAN FUNERAL HOME</b>				ADDRESS <b>308 HIGH ST CAMBRIDGE, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randell</b>			

BP



Item #6-fg598-12/20/84 jp

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

64-23645

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HARRY E. KARR, JR.			2a. DATE OF DEATH MONTH DAY YEAR September 1, 1984		2b. HOUR 4:30 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 5, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Lutherville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2014 W. Joppa Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive-Central Bank		12b. KIND OF BUSINESS OR INDUSTRY Savings
13a. STATE MD	13b. COUNTY Baltimore	13c. CITY OR TOWN Lutherville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2014 W. Joppa Road, 21093	
14. FATHER'S NAME FIRST MIDDLE LAST Harry E. Karr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Hoge			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 220 01 6622	17. INFORMANT ADDRESS Mrs. Virginia K. Karr, Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases to brain + meninges.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>3 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from <u>9/1/84</u> to <u>9/1/84</u> , that (I) (we) last saw the deceased alive on <u>9/1/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>W. S. Speed, MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/4/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William Speed, MD		22e. ADDRESS 11 E. Chase Street, Balto., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/5/84	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212		25a. DATE REC'D. BY REGISTRAR SEP 4 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, changes only injury, or other traumatic event, the medical examiner must be notified at once.





# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mason P. Kelly</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-14-84</b>		2b. HOUR <b>7:25 M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 15 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83 84</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. IF UNDER 1 YEAR MONTHS DAYS <b>11 1</b>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bland Bryant Nursing Center</b>		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Maryland</b>		12b. COUNTY <b>Baltimore</b>		12c. CITY OR TOWN <b>Luth.-Timon.</b>		
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS <b>905 Jamieson Road, Baltimore, Md 21093</b>		13c. LUTHERVILLE		
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVID WRIGHT KELLY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA STONE</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes 1918 WWI</b>		
17. SOCIAL SECURITY NO. <b>216-22-4827</b>		18. INFORMANT <b>FAMILY RECORDS</b>		19. ADDRESS		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Pulm Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic Pulm Fibrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gen. ASCVD</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>OBS</b>						
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>5/26</b> , 19 <b>77</b> , to <b>9/14</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.						
22b. SIGNATURE <b>Emma Woody MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-14-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Emma Woody MD</b>		22e. ADDRESS <b>P.O. Box 3235 Catonsville, Md. 21228</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/17/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MAURY CEMETERY</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>RICHMOND VA.</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 24 1984</b>				
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPEL OF CHIMES</b>		ADDRESS <b>TIMONIUM, MD. 2325 YORK RD.</b>		25. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>		

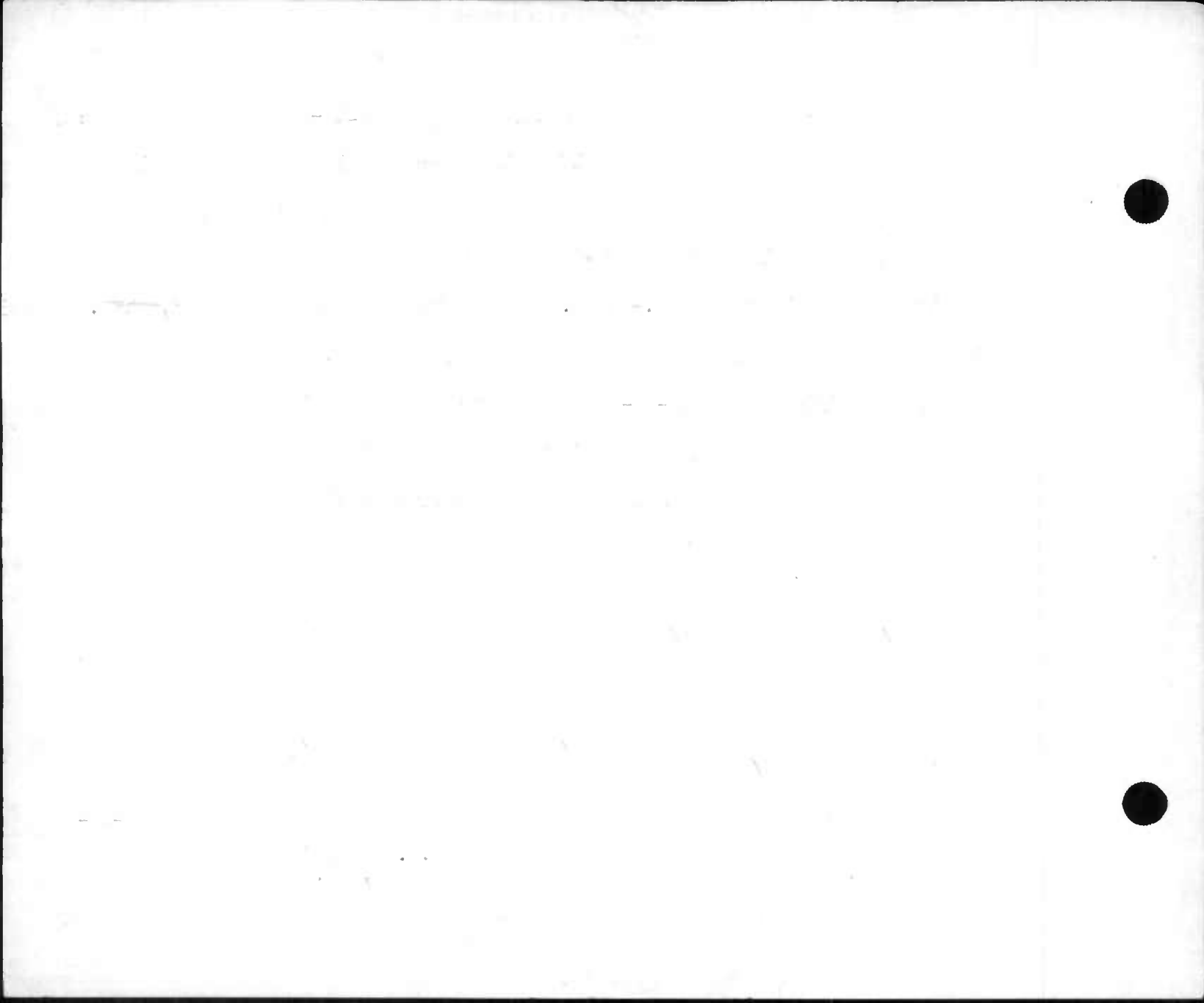
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DHMH-16 20M  
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

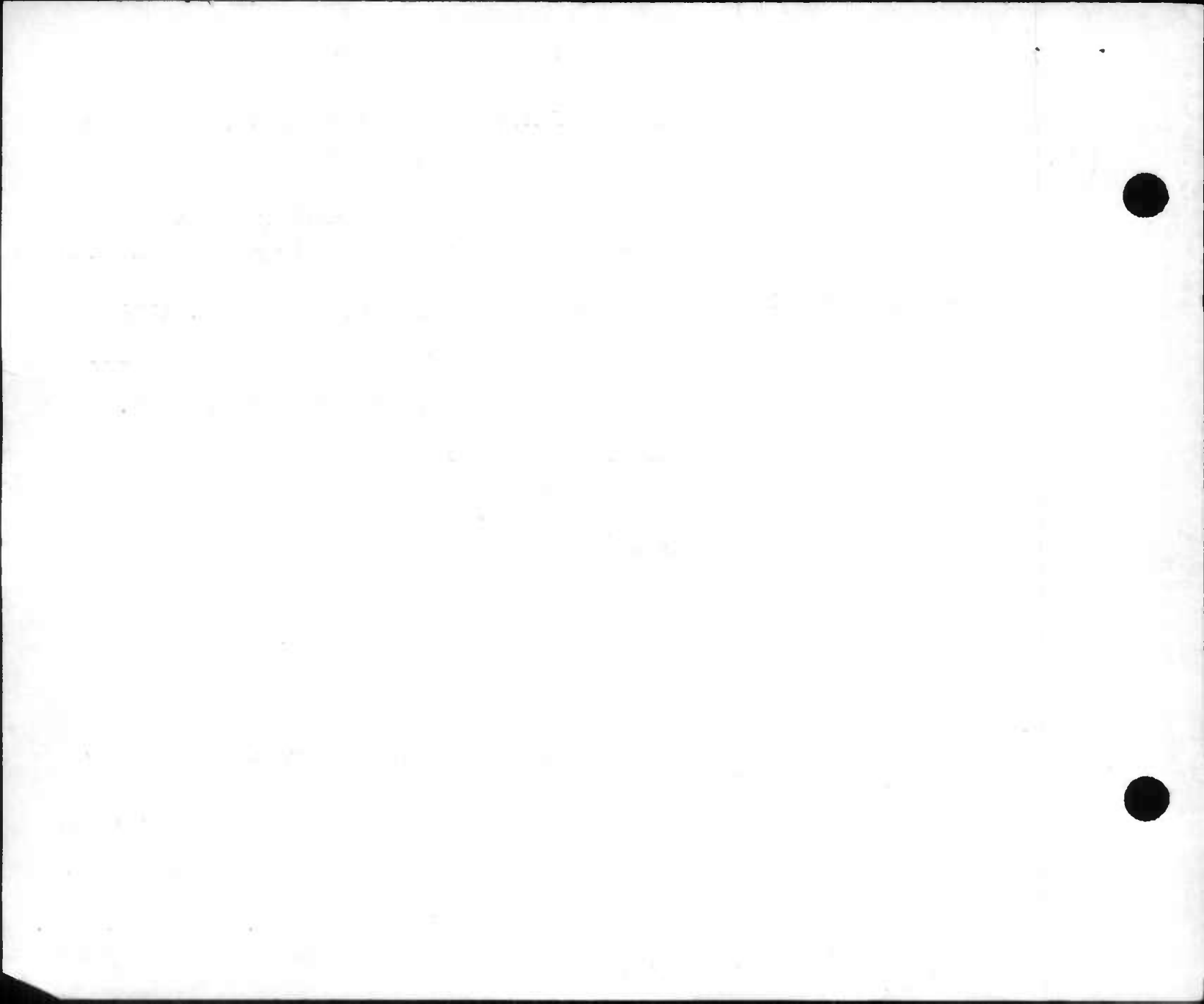
23647

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Rosa Marie KELLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 13, 1984</b>		2b. HOUR <b>4:15P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 15 14</b>		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>70</b>		
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FULL, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		13a. STREET ADDRESS / ZIP CODE <b>1104 CORD ST. 21220</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN BORLEIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA ---</b>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219187258</b>		17. INFORMANT ADDRESS <b>MARY LOU DUDLEY 1104 CORD ST.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Presumed sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Terminal Pancreatic Cancer</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>-----</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 11 19 84</b> to <b>September 13 19 84</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 13 19 84</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.						
22b. SIGNATURE <i>Carlos J. Page</i>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9/13/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLOS J. PAGE M.D.</b>		22e. ADDRESS <b>9000 FRANKLIN SQUARE DR/BALT, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/17/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GRADENS OF FAITH</b>		
24. FUNERAL DIRECTOR <i>Jeff Cook</i>		ADDRESS <b>1211 Chesapeake Ave</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. BALTO. MD.</b>		
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

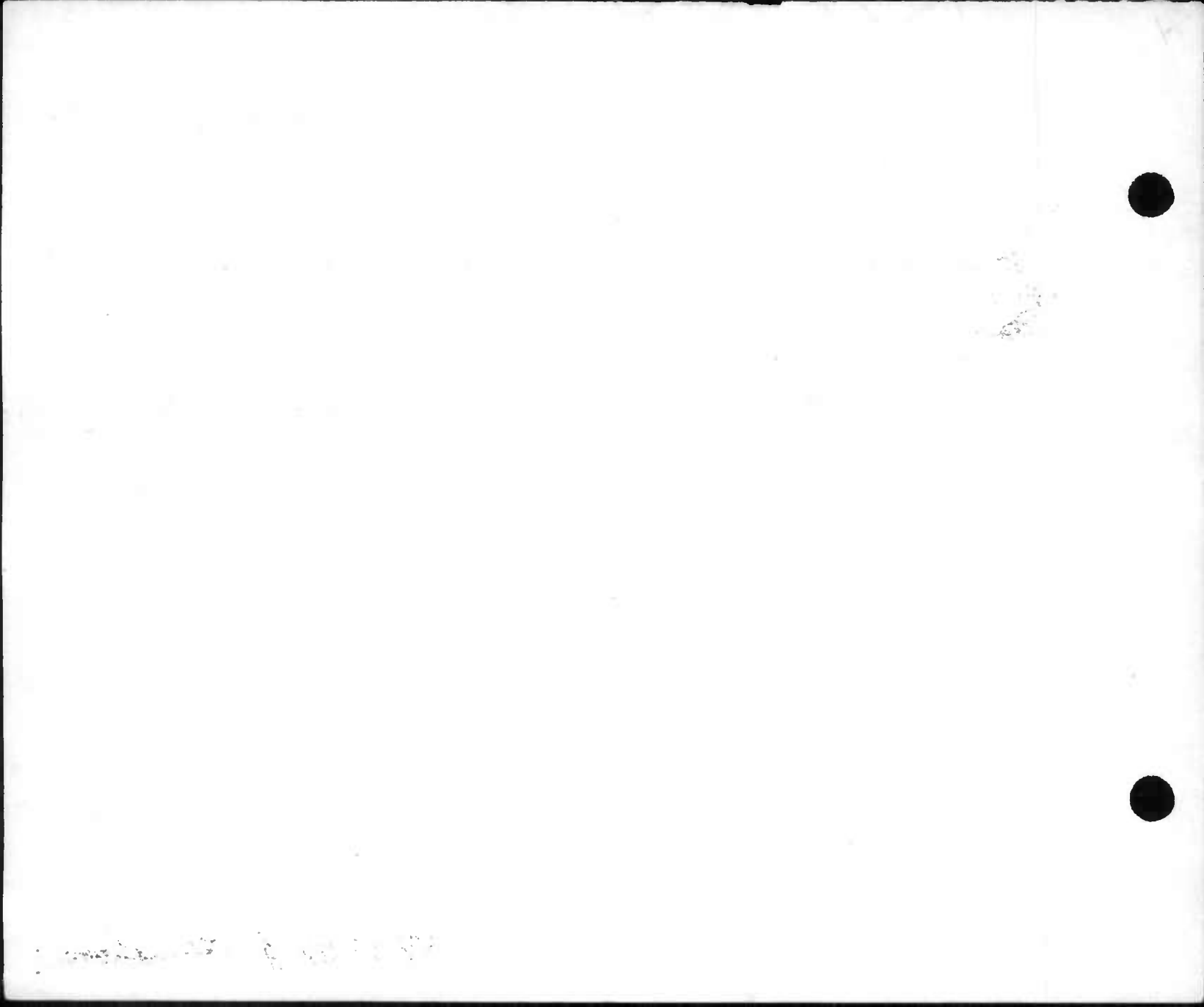
6 4 2 3 6 4 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>George T. Kelly</b>			2a DATE OF DEATH MONTH DAY YEAR <b>September 20, 1984</b>			2b HOUR <b>1000 PM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11 3 03</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>80</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>			
10 CITY OR TOWN OF DEATH <b>Catonsville</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5910 Prince George St.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer/Elect.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Electric</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Woodlawn</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>5910 Prince George St. 21207</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ivy W. Kelly</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mrs. Joyce Lane</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>218-09-8323</b>		17 INFORMANT ADDRESS <b>Mrs. Joyce Lane 5910 Prince George St.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cholesterol</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 mo.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from <b>6/23</b> 19 <b>84</b> to <b>9/20</b> 19 <b>84</b> that (1) (we) last saw the deceased alive on <b>9/20</b> 19 <b>84</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (we) did not view the body after death.									
22b SIGNATURE <b>Wm. C. Waterfield</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>9/21/84</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm. C. Waterfield</b>				22e ADDRESS <b>St Agnes Hospital 900 Caton Ave Balt 21229</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b DATE <b>9/21/84</b>		23c NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. Md.</b>			
24 FUNERAL DIRECTOR <b>Ambrose Funeral Home 1328 Sulphur Spring Rd.</b>				25a DATE REC'D. BY REGISTRAR <b>SEP 21 1984</b> 25b REGISTRAR'S SIGNATURE <b>John Davidson</b>					

BP



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23649			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 9-24-84			
1. DECEASED NAME FIRST MIDDLE LAST CATHERINE KERN				2b. HOUR 9:00 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 22 12		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FULLERTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7650 Belair Rd. (on parking lot)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY homemaking	
13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6414 Everall Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Lang				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ludwina Gutmann			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-24-6252		17. INFORMANT ADDRESS 21237 Mrs. Georgia L. Stegman 6709 Fordcrest Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 84, to Sept 19 84, that (I) saw the deceased alive on 9/24/84, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.							
22b. SIGNATURE OF ROBERT LYDEN, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT LYDEN, M.D.				22e. ADDRESS 6402 GOLDEN RING RD. (866-8400)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-27-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME				ADDRESS			

SEP 27

John Gordon Rodolph



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23850

1- FOR STATE REGISTRAR		2a DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Peter LEO Kerr</b>		2b DATE OF DEATH MONTH DAY YEAR <b>9/20/84</b>		2c HOUR M <b>4:55 A</b>	
3 SEX <b>Male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>6 11 95</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>89</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>TOWSON MD.</b>	
10 CITY OR TOWN OF DEATH <b>Towson Md.</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Multi Medical Nursing Center</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SHIP FITTER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>BETH STEEL</b>	
13a STATE <b>MARYLAND</b>		13b COUNTY <b>BALTO.</b>		13c CITY OR TOWN <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		13d STREET ADDRESS <b>31334 MORELAND AVE</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD KERR</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY MACDONALD</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO. <b>213-07-1579</b>	
17 INFORMANT <b>FAMILY RECORDS</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cachexia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>Stroke part central vascular accident</b>		19a DATE OF OPERATION <b>Min</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Arteriosclerotic Heart</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>8/31/84</b> to <b>Sept 20 19 84</b> , that (I) (we) last saw the deceased at <b>8/31/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE <b>A. H. Janoski</b>		DEGREE <b>M.D.</b>		22c DATE SIGNED <b>7/20/84</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. H. Janoski</b>		22e ADDRESS <b>7600 Oak Pine Turnpike 21204</b>		23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>9/22/1984</b>	
23c NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. CITY MD.</b>		24 FUNERAL DIRECTOR NAME <b>EVANS-CHAPEL OF MEMORIES</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 24 1984</b>	
25b REGISTRAR'S SIGNATURE <b>John K. Anderson</b>							

BP



20% cotton blend

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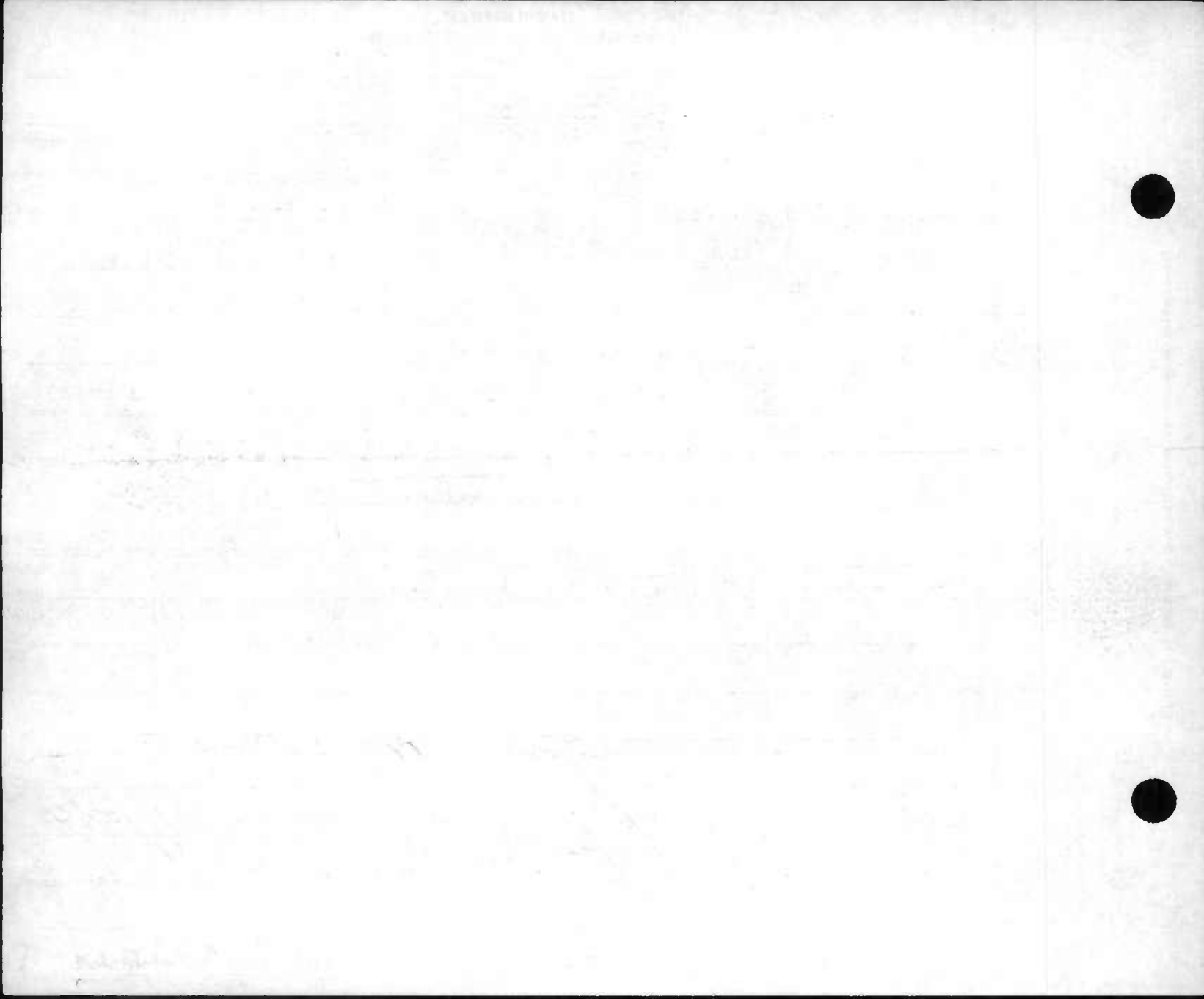
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. FOR STATE REGISTRAR					2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.									
1. DECEASED NAME (TYPE OR PRINT) HARRY W. KILPATRICK					2a. DATE OF DEATH MONTH DAY YEAR 9 22 84					2b. HOUR M				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2 23 14		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.				
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7d. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City. Co. MD.								
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1106 Glensford Rd.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician		12b. KIND OF BUSINESS OR INDUSTRY Aircraft					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Md. Balto. Balto.					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1106 Glensford Rd. 21221							
14. FATHER'S NAME FIRST MIDDLE LAST Harry W. Kilpatrick					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 205-03-1047		17. INFORMANT ADDRESS Mrs. Gladys E. Kilpatrick - Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic small cell lung cancer DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral metastases of (a) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Intestinal obstruction, Diabetes														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from October 19 79 to September 22 84, that (I) (we) last saw the deceased alive on Sept 22 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not view the body after death).														
22b. SIGNATURE Louis J. E. Hoff										DEGREE		22c. DATE SIGNED 10/3/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS J. E. HOFF										22e. ADDRESS 2108 CRENSHAW BLVD BALTO MD 21220				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 9/22/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE								
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 11 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 6 15 2

1. DECEASED NAME (TYPE OR PRINT) PARKER H. KING			2a. DATE OF DEATH MONTH DAY YEAR 9 29 84			2b. HOUR P 12:30M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 4 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5 Kingston Park Rd. 21220			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY C. & P. Tel.Co	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN		
14. FATHER'S NAME FIRST MIDDLE LAST Parker H. King, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Brown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-0432		17. INFORMANT ADDRESS Mary M. King 5 Kingston Park Rd. 21220				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>months.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>malnutrition</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOURS AM MONTH DAY YEAR 10 9 29 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>9/29/84</u> to <u>death</u> 19 <u>84</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100) (101) (102) (103) (104) (105) (106) (107) (108) (109) (110) (111) (112) (113) (114) (115) (116) (117) (118) (119) (120) (121) (122) (123) (124) (125) (126) (127) (128) (129) (130) (131) (132) (133) (134) (135) (136) (137) (138) (139) (140) (141) (142) (143) (144) (145) (146) (147) (148) (149) (150) (151) (152) (153) (154) (155) (156) (157) (158) 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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23653	
1- STATE REGISTRAR					1 DECEASED NAME FIRST MIDDLE LAST Larry Gene KIRBY, Sr.			2a DATE OF DEATH MONTH DAY YEAR September 26, 1984		2b HOUR 1:30a M	
3. SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 24 1939		6 AGE (IN YEARS LAST BIRTHDAY) 45 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor-Monarch Rubber			12b KIND OF BUSINESS OR INDUSTRY Co.		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7314 Betz Avenue 21219		
14. FATHER'S NAME FIRST MIDDLE LAST Hugh Fields			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Kirby								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT Kathleen A. Kirby		ADDRESS Same as 13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Adeno-carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hyperealecemia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 16, 1984</u> to <u>September 26, 1984</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>September 26, 1984</u> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did/did not) view the body after death.											
23a SIGNATURE <i>Michael G. Taylor</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/26/84					
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Taylor, M.D.		22e ADDRESS 9000 Franklin Square Dr., 21237									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/29/84		23c NAME OF CEMETERY OR CREMATORY Oak Lawn		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222						25a DATE REC'D. BY REGISTRAR SEP 27 1984		25b REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Archie Richard Kirkpatrick</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 22, 1984</b>		2b. HOUR M <b>AM</b>		
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 15, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co., Md.</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Kirkpatrick</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579 05 9340</b>		17. INFORMANT ADDRESS <b>Mr. John F. Kirkpatrick 3025 Linwood Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u> <u>40 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Diabetes mellitus</u> <u>6 mos.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>the hospital</del> attended the deceased from <u>March 8, 1975</u> to <u>Sept. 22, 1984</u> that (I) <del>was</del> last saw the deceased alive on <u>Aug. 27, 1984</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Marvin Goldstein</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/24/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARVIN GOLDSTEIN</u>		22e. ADDRESS <u>6001 Park Heights Ave. Balto., MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/24/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>MITCHELL-WIEDEFELD HOME, INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by the health department.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. HOUR	
MARGARET KLEIN		9 24 84		11 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Female	White	12 24 21	63		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH		
Kansas	U.S.A.		Baltimore County MD		
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
Towson	St. Mary's Hospice	Clerical			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	17. STATE	18. COUNTY	19. CITY OR TOWN	20. INSIDE CITY LIMITS?	21. STREET ADDRESS / ZIP CODE
Md.			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2308 Cloville Ave. 21214
22. FATHER'S NAME (TYPE OR PRINT)	23. MOTHER'S MAIDEN NAME (TYPE OR PRINT)	24. MOTHER'S MAIDEN NAME (TYPE OR PRINT)			
Charles Elmer Blackburn	Josephine Livers				
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	26. SOCIAL SECURITY NO.	27. INFORMANT		28. ADDRESS	
no	512-12-0188	Cheryl Aiken		775 White Oak Dr. Belair 21014	
29. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain Tumor</u>					
DUE TO: OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO: OR AS A CONSEQUENCE OF					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
30. DATE OF OPERATION	31. CONDITION FOR WHICH OPERATION WAS PERFORMED	32. AUTOPSY?	33. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
34. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)	35. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	36. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
37. INJURY OCCURRED	38. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	39. LOCATION	40. CITY OR TOWN		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
41. I certify that (I, this hospital) attended the deceased from <u>September 20, 1984</u> to <u>September 21, 1984</u> , that (I, we) last saw the deceased alive on <u>September 20, 1984</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I, we) did (did not) view the body after death.					
42. SIGNATURE	43. DEGREE	44. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	45. DATE SIGNED		
<u>H. Faulkner MD</u>			9/21/84		
46. PHYSICIAN'S NAME (TYPE OR PRINT)	47. ADDRESS	48. DATE REC'D. BY REGISTRAR			
FAULKNER	2300 Dulany Valley Rd / Baltimore	SEP 24 1984			
49. BURIAL, CREMATION, REMOVAL (SPECIFY)	50. DATE	51. NAME OF CEMETERY OR CREMATORY	52. LOCATION		
Burial	9/25/84	Moreland	Baltimore, Maryland		
53. FUNERAL DIRECTOR	54. ADDRESS	55. DATE REC'D. BY REGISTRAR		56. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc.	5305 Harford Rd. 21214	SEP 24 1984		[Signature]	

tex:1


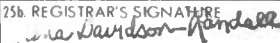
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23856

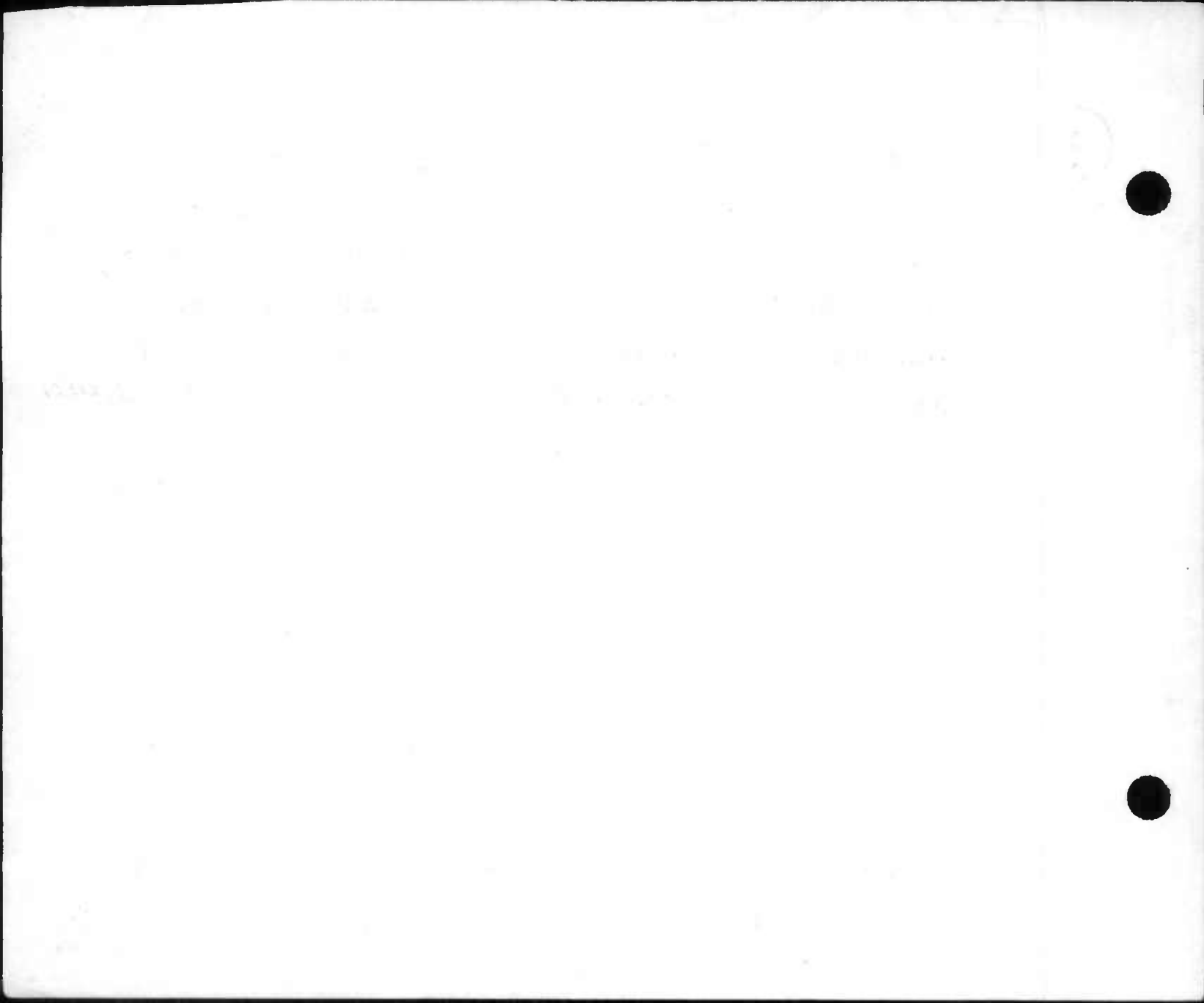
1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ANTON KLIER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 11 '84</b>		2b. HOUR MIN. <b>10:00 A</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 19 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>90</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>AUSTRIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BAKER</b>	
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>BERNHARD KLICER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRANZISKA 7</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-32-1688</b>		17. INFORMANT ADDRESS <b>FRANCES KLIER 2507 GLENCOE RD. 21234</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASYSTOLE 2nd TO COMPLETE A-V BLOCK</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MINUTES</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ISCHEMIC HEART DISEASE</b>					<b>1 YEAR</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>					<b>1 YEAR</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/10</b> , 19 <b>84</b> , to <b>9/11</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign this body after death.					
22b. SIGNATURE 				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EMILIO B. LOBATO, M.D.</b>				22e. ADDRESS <b>GBMC - 6701 N. CHARLES ST. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>SEPT. 12, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>
24. FUNERAL DIRECTOR NAME <b>HARTLEY MILLER</b>		ADDRESS <b>7527 HARTFORD RD</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>	
25b. REGISTRAR'S SIGNATURE 					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR 115 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23651  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
EVELYN M. KLOFFKE		9 17 1984		1045 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Female	White	August 20, 1902	82 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	U.S.A.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore County	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown	Baltimore County General Hospital	Housewife		Own Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Baltimore	Catonsville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	217 E. Medwick Garth 21228	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
George Bopp		Matilda (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		219-54-3925		6539 Redgate Circle, Catonsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) ASCVD					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I have charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		DATE SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
E.P. Williams		3550 Patton Ave		21228	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9/20/84		Loudon Park Cemetery	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Baltimore		SEP 19 1984		Lelia Davidson-Randall	
24. FUNERAL DIRECTOR					
Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228					

SEP 1 1932



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MINNIE</b> <b>Kohler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 14 1984</b>		2b. HOUR MIN. <b>10:24</b> <b>AM</b>
3. SEX <b>Female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>August 17 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK) <b>Assorter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fun Decorator- ring Co.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>13c.</b> 13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Miller</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-05-5964</b>		17. INFORMANT ADDRESS <b>21218</b> <b>Mrs. Charles James 1612 Lochwood Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic cardiac vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>multiple uninfected decubiti</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>over 2 years</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>22 July 82</b> , to <b>14 September 84</b> , that (I) (we) last saw the deceased alive on <b>14 Sept 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Walter T. Kees</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>14 Sept 1984</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Walter T. Kees</b>		22e. ADDRESS <b>Monkton, Md 21111</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-17-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>		24. FUNERAL DIRECTOR <b>Schumnek Funeral Home, Inc.</b> <b>3331 Brehms Lane, Balto., Md. 21213</b>			
25. DATE RECEIVED BY DEPT. OF HEALTH AND MENTAL HYGIENE <b>SEP 18 1984</b>		25. REGISTRY NO. <b>John Barker</b>			



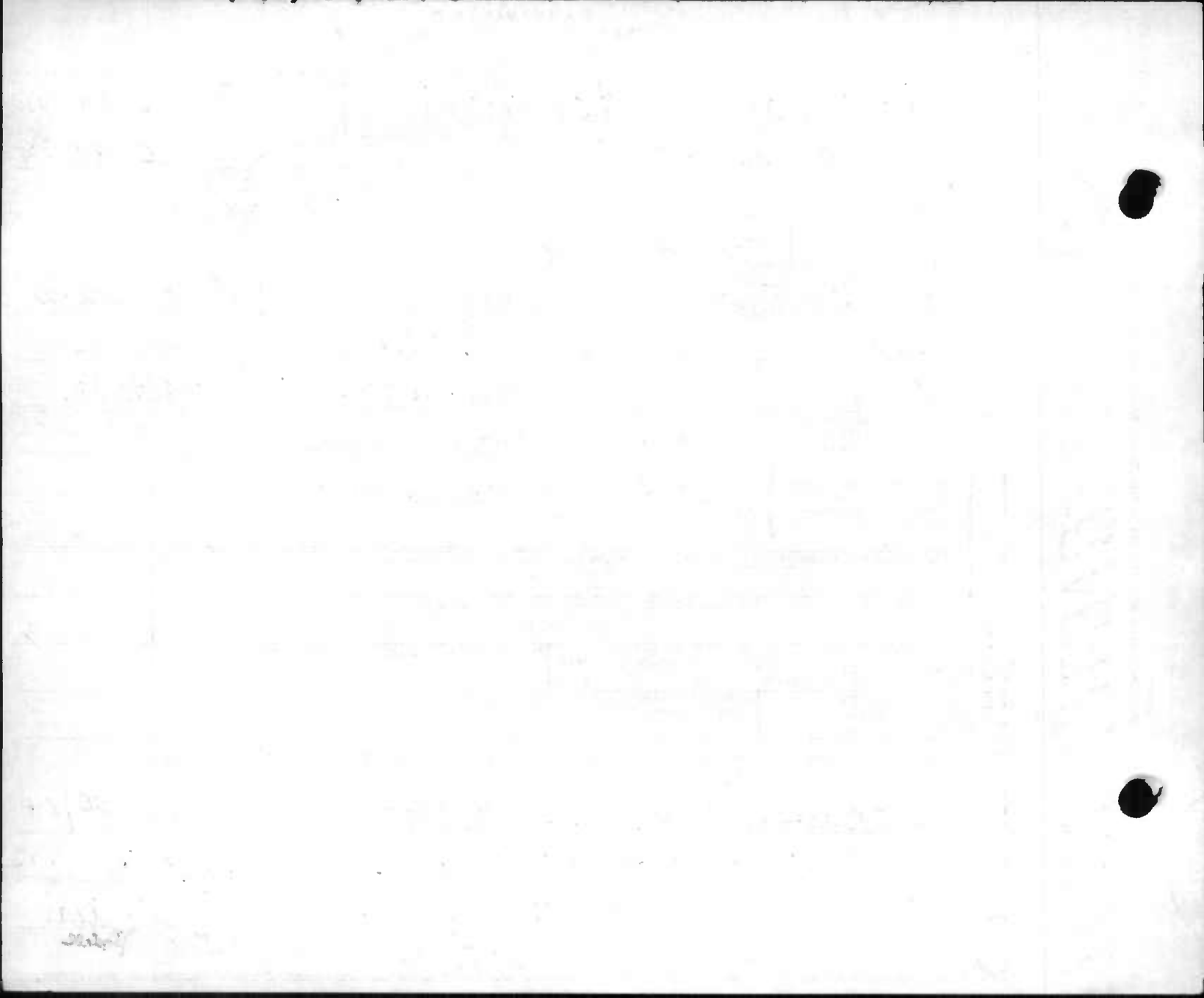
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23059

1. DECEASED NAME (TYPE OR PRINT) <b>Alexander Kowalski</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>9/20/84</b>		2b. HOUR <b>0030</b>			
3. SEX <b>M</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 9 1901</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>83</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		21. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Sept 20 1984</b>		2d. HOUR <b>1300</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.									
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>530 48th St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>530 48th St. 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Kowalski</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Victoria Rozmus</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Anna Kowalski</b>				ADDRESS <b>530 48th St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>J.C. William O'Donovan</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>9/20/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>				ADDRESS <b>2112 Dundalk Ave., Balto, Md. 21222</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>9-22-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Raymond L. Kuzowski</b>				ADDRESS <b>2525 Clut St.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1984</b>				25b. REGISTRAR'S SIGNATURE <b>John David W. Wadell</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

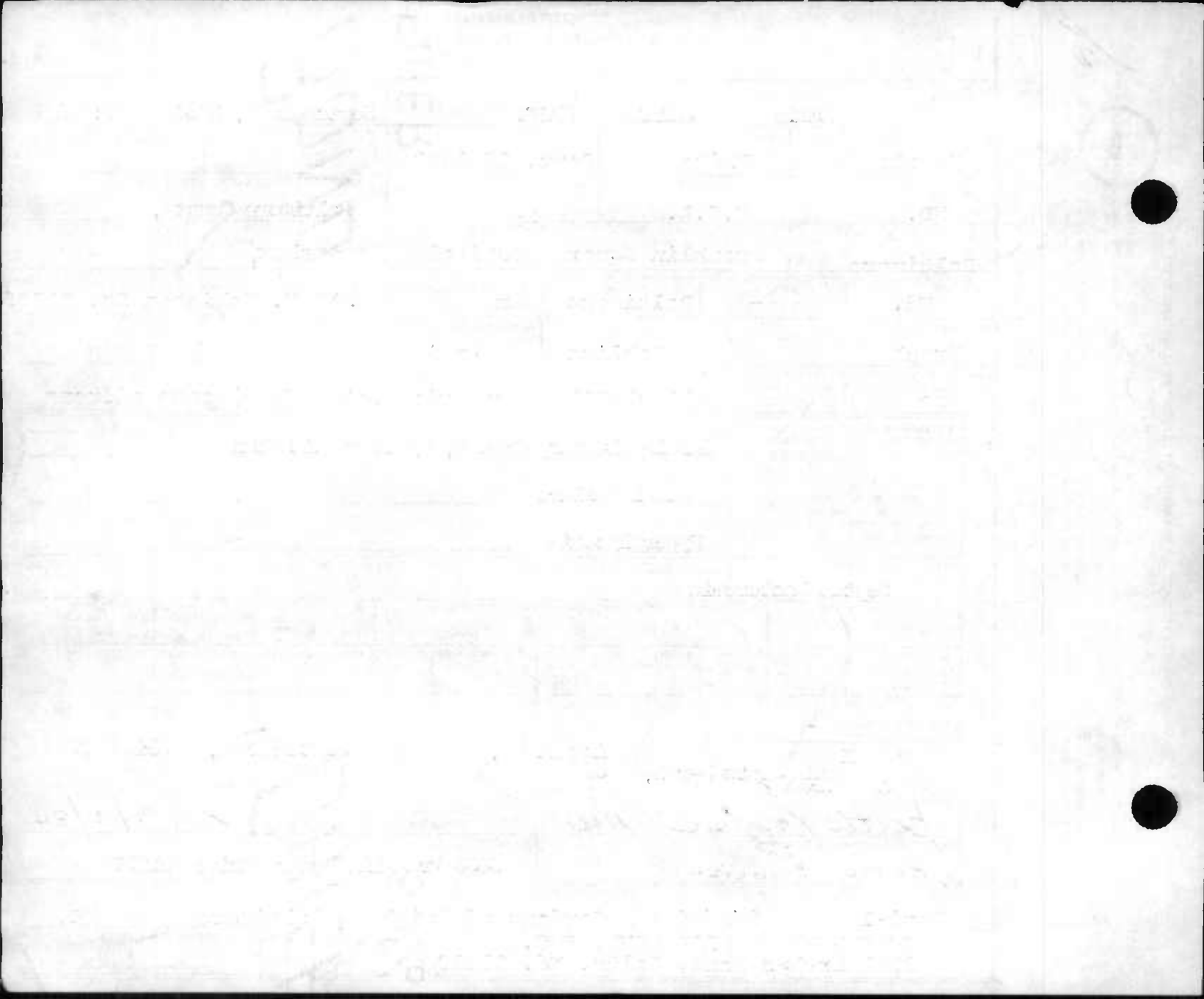
REG. NO.

2 3 0 6 0

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mamie Luticia KRAFT			2a. DATE OF DEATH MONTH DAY YEAR September 2, 1984			2b. HOUR 7:00A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 26 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.					13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 613 N. Robinson St. 21205		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Boblitz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucina Young						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-3376		17. INFORMANT ADDRESS Frederick Getz (son) same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest, Hyperosmotic Coma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hyperglycemia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Septic Bacteremia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 24, 1984, to September 2, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on September 2, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not touch the body after death.									
22b. SIGNATURE Keith English MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/2/84	
22d. PHYSICIAN'S NAME KEITH ENGLISH				22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/5/84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL HOME NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR SEP 5 1984		25b. REGISTRAR'S SIGNATURE - [Signature] -			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, except by  
retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23061

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edna M. Kress</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 25 84</b>		2b. HOUR <b>1:45 P.M.</b>
3. SEX <b>F</b>	4. RACE <b>Cau.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 31 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>81 YRS.</b> MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Ruxton</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleslady</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b>			13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Konig</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217-03-0292</b>		17. INFORMANT ADDRESS <b>Frederick W. Kress 1812 Ellinwood Rd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>- Congestive heart failure.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A-S-C.V.-D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>stroke Cerebro-vascular accident.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <b>5/21 19 84</b> , to <b>9/25 19 84</b> , that (b) (we) lost saw the deceased alive on <b>9/25 19 84</b> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W. J. Jones</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/26/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. M. TUN.</b>		22e. ADDRESS <b>Manor Care Towson.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-27-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>JOHN C. MILLER, INC.</b>		ADDRESS <b>6415 BELAIR RD.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

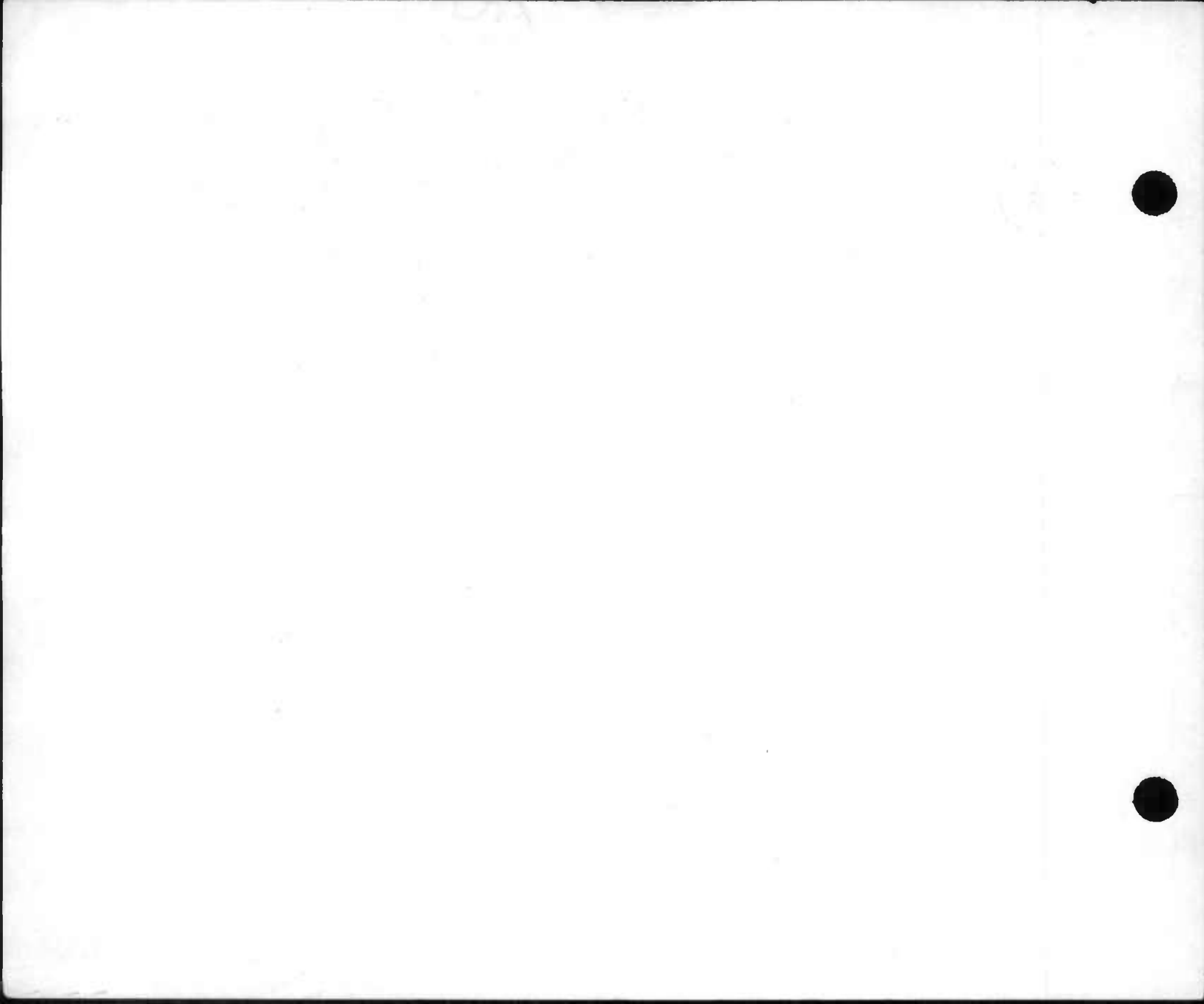
1. DECEASED NAME (TYPE OR PRINT) <b>MAMIE L. KUHN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 29, 1984</b>		2b. HOUR <b>12<sup>30</sup> AM</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>OCT 14 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wife Home</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MURRAY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HASH</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Atherosclerotic CV Dis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 18a <b>Pneumonia, Influenza like</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>9/18</b> , 19 <b>84</b> , to <b>9/29</b> , 19 <b>84</b> , that (we) last saw the deceased alive on <b>9/29/84</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE <b>LESTER A. WALL JR. MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/29/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>7620 York Rd Towson MD 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (IF BY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
<b>BURIAL</b>	<b>10-2-84</b>	<b>MOORELAND MEN. PK</b>		<b>BALTO CO MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>EVANS CHAPEL of MEMORIES 8800 Hartford Rd</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>W. J. Wilson-Randall</b>	
		<b>OCT 2 1984</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



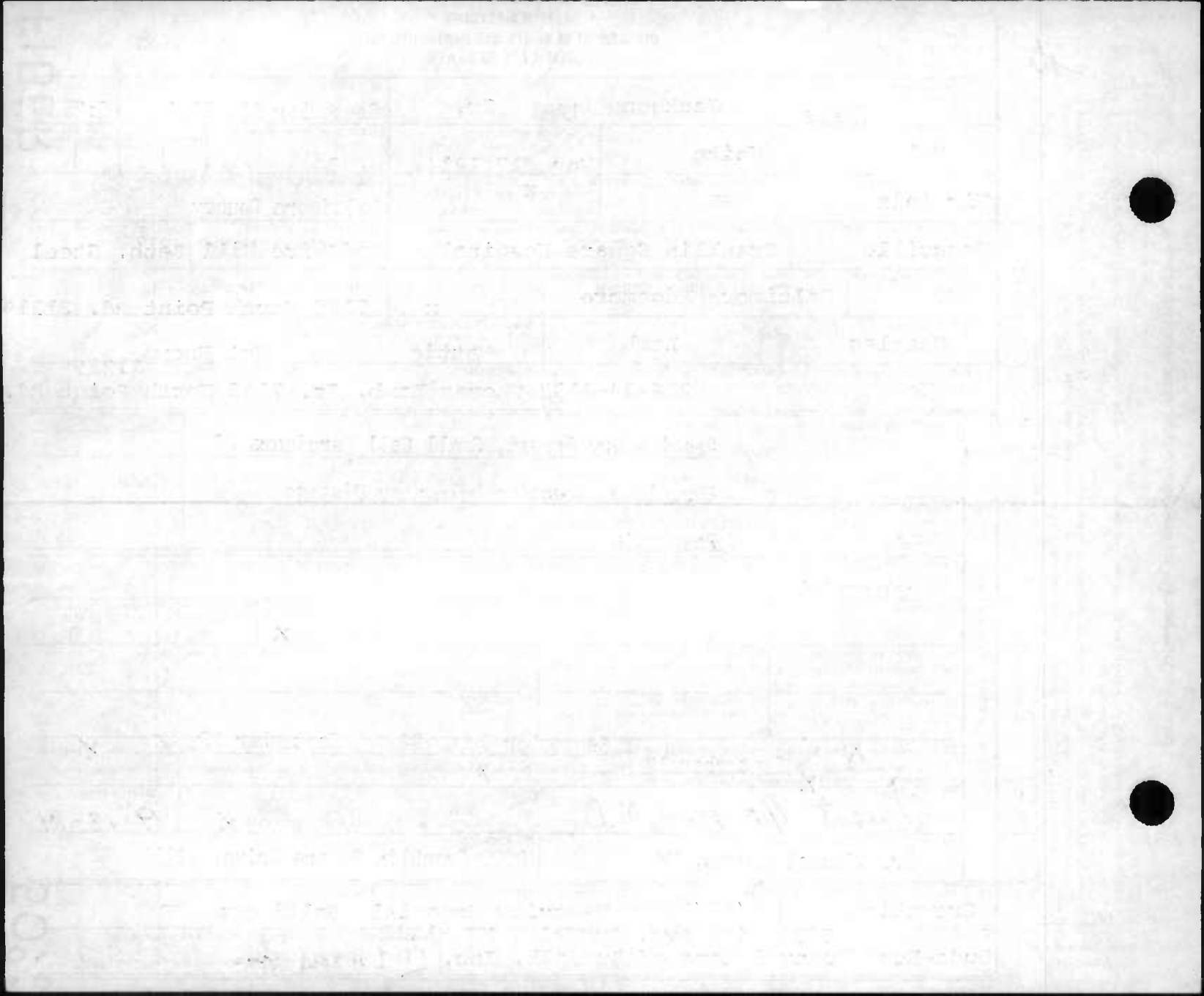
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopoppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 23663							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Jackson LAMB Sr.						2a. DATE OF DEATH MONTH DAY YEAR September 13, 1984		2b. HOUR 9:25 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 17 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Rod&Wire Mill		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7105 North Point Rd. 21219	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Lamb				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Not Known 21219					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 226-24-5137		17. INFORMANT ADDRESS Thomas Lamb, Jr. 7105 North Point Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest, Small Cell Carcinoma Of Lung DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Malnutrition									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 9, 1984, to September 13, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on September 13, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Vincent Morgan, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-13-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Vincent Morgan, Md				22e. ADDRESS 9000 Franklin Square Drive, 21237					
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 9/15/84		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD			
24. FUNERAL DIRECTOR 7922 Wise Ave. Dundalk, MD 21222 Duda-Ruck Funeral Home of Dundalk, Inc.									
25. DATE REC'D. BY REGISTRAR SEP 18 1984						25b. REGISTRAR'S SIGNATURE John L. ...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23064

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUTH N LANCE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/14/84</b>			2b. HOUR <b>9:35 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 5 1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>A.T.T.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Noel Ellis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nora Lemons</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>232-52-0338</b>	
17. INFORMANT <b>Victor E. Lance</b>		ADDRESS <b>804 Mockingbird La. Apt. 204</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Molt-plt Organ Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Adenocarcinoma of the Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION <b>9/11/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Adenocarcinoma of Pancreas</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/13</b> , 19 <b>84</b> , to <b>9/14</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Leon N. Palacopoulos M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9/14/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leon N. Palacopoulos M.D.</b>				22e. ADDRESS <b>St. Joseph Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/17/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld</b>				ADDRESS <b>6500 York Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>Gula Davidson-Rodale</b>			

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ALVIN M. LANGE

BALTIMORE COUNTY

TOWSON 6135th Hospital

WOMEN'S HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

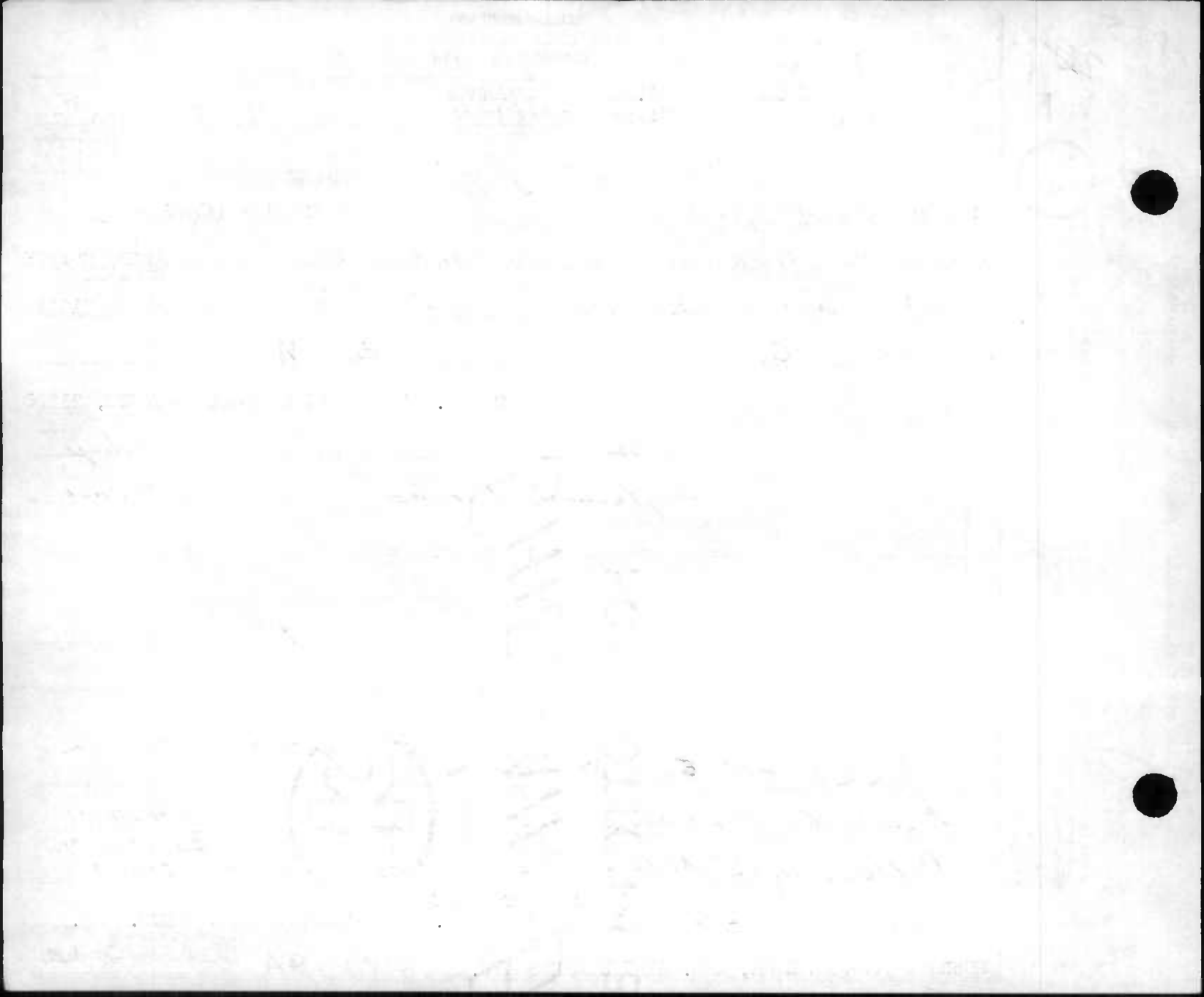
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PAUL ALLEN LANMAN</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>9</b> YEAR <b>84</b> 7b. HOUR <b>13<sup>45</sup> AM</b>		
3. SEX <b>m</b>	4. RACE <b>w</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>2</b> YEAR <b>14</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Catonsville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN CATONSVILLE N.H.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OWNER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>WELDING SUPPLY COMPANY</b>	
13a. STATE <b>MD</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>CATONSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>5612 WILKINS AVE 21228</b>	
14. FATHER'S NAME FIRST <b>CLAUDE</b> MIDDLE <b>C.</b> LAST <b>LANMAN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>NELE</b> MIDDLE <b>B.</b> LAST <b>MOBERLY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-03-1566</b>		17. INFORMANT <b>ELTON L. LANMAN 5612 WILKENS AVENUE, 21228</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Alzheimer's Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>4 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>19 80</b> to <b>Sept. 9</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Sept 8</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Doris R. Moseman, M.D.</b>				22c. DATE SIGNED <b>9-9-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. Moseman, M.D.</b>				22e. ADDRESS <b>5205 East Drive Arbutus, Md 21227</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>09-12-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>(UNITED METHODIST) STABLERSVILLE CH. CEM</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PARKTON BALTO. MD.</b>	
25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAZEL LANTZ			2a. DATE OF DEATH MONTH DAY YEAR Sept. 14, 1984			2b. HOUR 8:00A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 11, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Clarksburg, W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1004 N. Marlyn Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alvin E. Ruble		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Payne		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None	
17. INFORMANT ADDRESS 617 Elmina St. Morgantown, W. Va.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>34 yrs.</u>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <u>Sept. 10</u> , 19 <u>83</u> , to <u>Sept. 14</u> , 19 <u>83</u> , that (b) (we) lost <u>the deceased</u> <u>on 9/17/84</u> 19 <u>84</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Jeffrey M. Pargament</u> DEGREE <u>M.D.</u>				22c. DATE SIGNED <u>9/14/84</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey M. Pargament M.D.				22f. ADDRESS 9518 Phila. Rd. Suite 8 Balto. Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/18/1984		23c. NAME OF CEMETERY OR CREMATORY Beverly Hills Mem		23d. LOCATION CITY OR TOWN COUNTY STATE Morgantown Monongalia W. Va.	
24. FUNERAL DIRECTOR NAME E. Barnes Fleming Funeral Service - Benson, Md.				25a. DATE REC'D. BY REGISTRAR SEP 19 1984			
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pondell</u>			



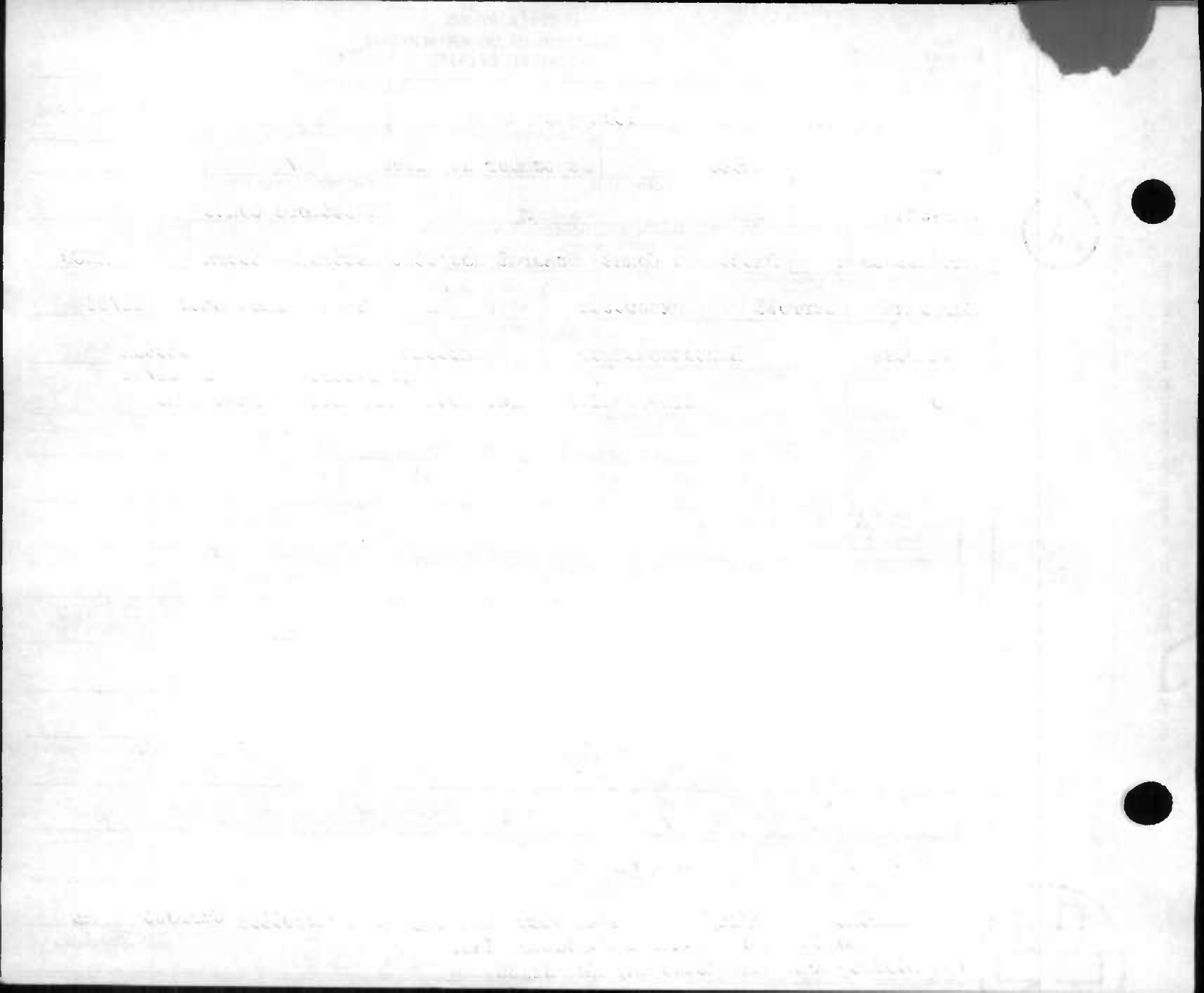
**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

23067

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles Adam Lautenschlager</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 10 84</i>		2b. HOUR <i>4:30 A M</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>September 26, 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>74</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore County General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired - Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>ARCO</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Carroll</i>	13c. CITY OR TOWN <i>Sykesville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Lautenschlager</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Matilda Wittich</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>212-09-4137</i>		17. INFORMANT <i>Sykesville, MD 21784</i> <i>Mrs. Lois Hand 2608 Barnes Lane</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia: Diabetes. 22.7.1</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension. C.V.A.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8 22 19 84</i> to <i>9 10 19 84</i> that (I) (we) last saw the deceased alive on <i>9 10 19 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>RAYADURG GOVINDA RAO</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RAYADURG GOVINDA RAO</i>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/14/84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Memorial Pk</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sykesville Carroll MD</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Director, Inc.</i> <i>8728 Liberty Rd. Randallstown, MD 21133</i>			25a. DATE REC'D. BY REGISTRAR <i>SEP 11 1984</i> 25b. REGISTRAR'S SIGNATURE <i>Jana Wilson-Randall</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ETHEL R LEIGHTON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT 1, 1984</b>				2b. HOUR <b>2:30 PM</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 4 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>60</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CO</b> MD.			
10. CITY OR TOWN OF DEATH <b>AERO ACRES</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10 NAVIGATOR COURT</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKER</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>AERO ACRES</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>10 NAVIGATOR COURT. 21220</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HIRAM J TAYLOR SR</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NELLIE BARBER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>219-16-5310</b>		17. INFORMANT ADDRESS <b>ROBERT. LEIGHTON 10 NAVIGATOR COURT</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure, Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic CAD, CUD, COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/27</b> , 19 <b>84</b> , to <b>8/31</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>8/31</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Steven S. Steinberg MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>9/3/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN STEINBERG</b>				22e. ADDRESS <b>3502 CROYDON RD 21208</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/5/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO CITY MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Lorraine Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 2 3 6 6 9  
REG. NO.

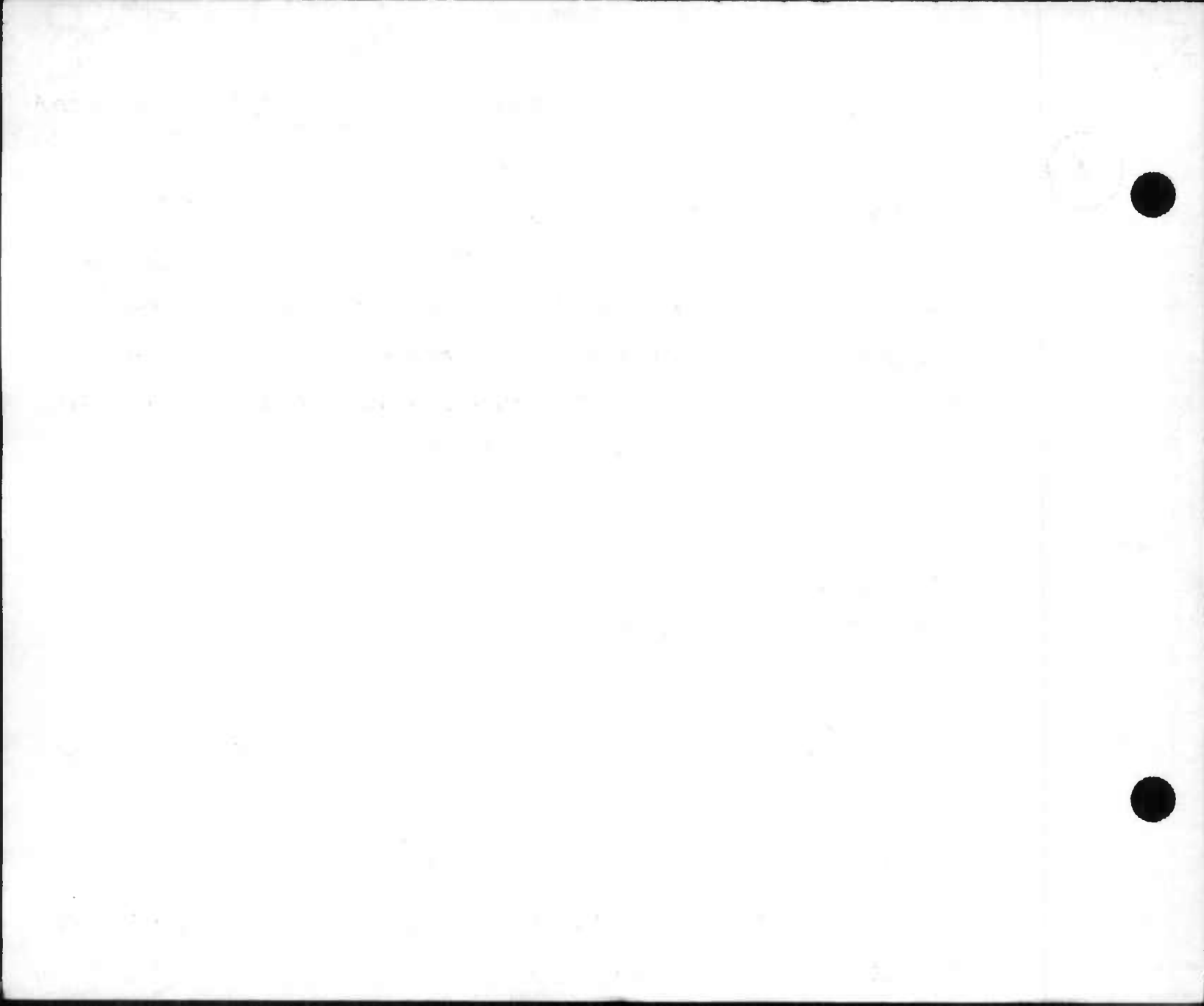
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST ALICE		MIDDLE E		LAST LEONARD		2a. DATE OF DEATH MONTH DAY YEAR SEPT 14 1987		2b. HOUR 3:20 A.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 07 21 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County						MD.	
10. CITY OR TOWN OF DEATH RINDAUSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietician		12b. KIND OF BUSINESS OR INDUSTRY Hospital							
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN MARIOTTVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3732 Woods Chapel Rd.				21104	
14. FATHER'S NAME FIRST MIDDLE LAST John Hofstetter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna UNK		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-36-2336		17. INFORMANT George Leonard		ADDRESS MARIOTTVILLE, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HIP CRACKING LEFT													
19a. DATE OF OPERATION 9-5-1987		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED HIP CRACKING LEFT				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I am a) ( ) attended the deceased from 13 February 1987 to 14 September 1987, that (I) last saw the deceased on 13 September 1987, and that in my ( ) opinion death occurred on the date and hour and from the causes stated above, (I) ( ) did not view the body after death.													
22b. SIGNATURE (Signature)		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-14-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATHAN M. LEBSON MD		22e. ADDRESS 3610 FORDS LANE RAND MD 21135											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-17-87		23c. NAME OF CEMETERY OR CREMATORY Woods Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE MARIOTTVILLE Balto - Md.							
24. FUNERAL DIRECTOR NAME Harry W. Knight		ADDRESS Lykensville, Md.		25. DATE REC'D BY REGISTRAR SEP 14 1987									

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 4 2 3 6 7 0  
REG. NO.

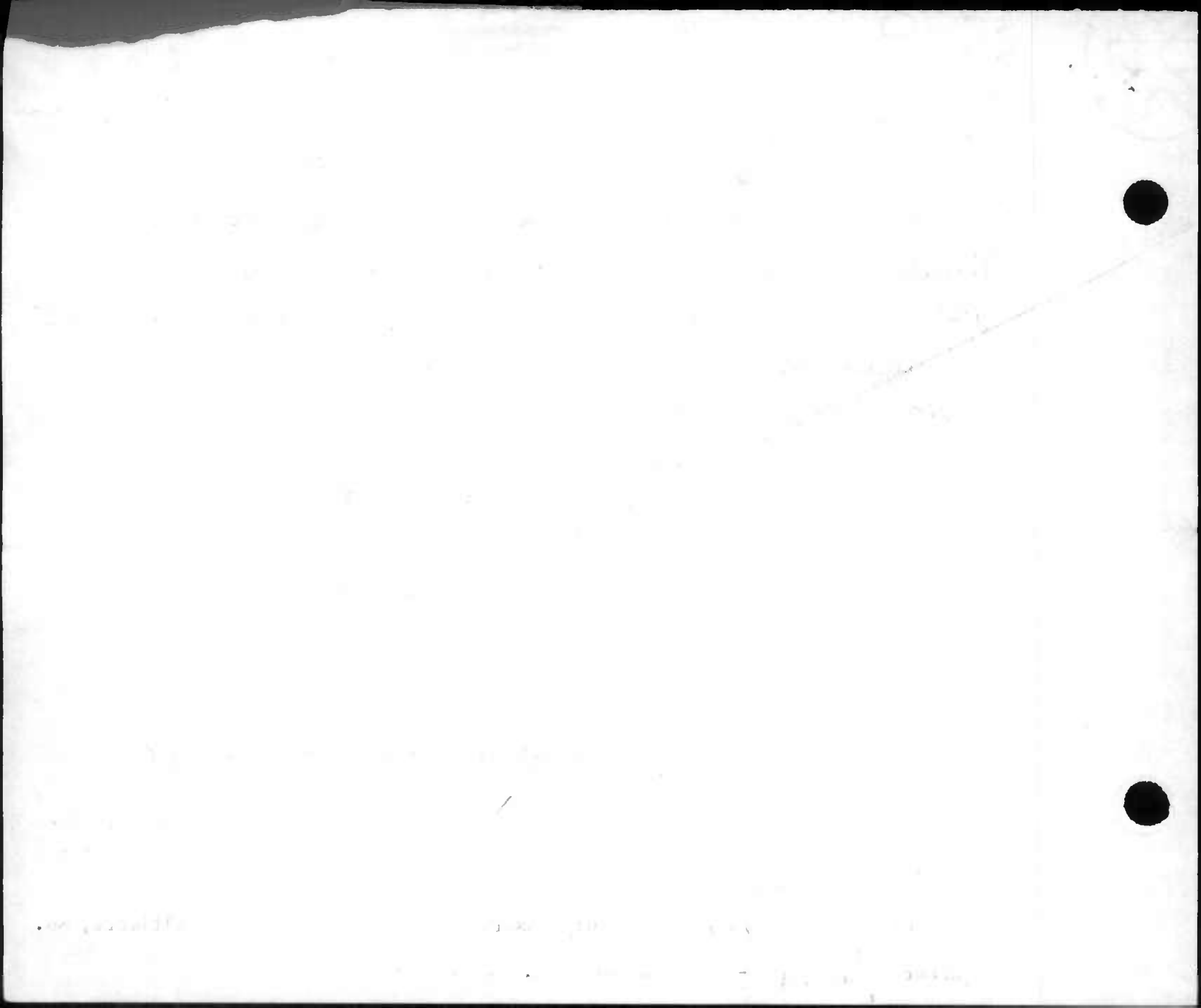
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen Lerch</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>9 16 84</i>		2b. HOUR M <i>12 noon</i>	
3. SEX <i>Female</i>	4. RACE <i>Cauc.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 13 02</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore Co.</i> MD.
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Balto. Co. Gen. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Md.</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Urinary tract infection</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hepatitis 2 with secondary infection</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 4, 1984</i> to <i>Sept. 16, 1984</i> , that (I) (we) last saw the deceased alive on <i>Sept. 16, 1984</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Sharon Pounmatabed</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>9-16-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GHASSEM POUNMATABED</i>		22e. ADDRESS <i>Balto. Co. General Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>9/19/84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Walter Dabrowski</i>		ADDRESS <i>- 1005 Dundalk Ave. 21224</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 21 1984</i>	
				25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 6 7 1

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
EVA LERNER		9 20 84		6 <sup>12</sup> A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))	IF UNDER 1 YEAR	
FEMALE	WHITE	12 23 99	84 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
(RUSSIA) USSR	USA		Balto. County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
RANDALLSTOWN	BALTIMORE COUNTY GEN. HOSP.		HOUSEWIFE		A T HOME
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND	BALTO.	RANDALLSTOWN	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3734 SPRINGDELL AVE. #21133	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
TOBIAS POLANSKY	JENNIE POPKIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
NO	218-32-2395	MRS. MIRIAM YANKELOVE			
		3734 SPRINGDELL AVE. RANDALLSTOWN, MD 21133			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
(b) <u>CARDIAC ARRHYTHMIA</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>ANTERO SEPTAL MYOCARDIAL INFARCTION</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-20</u> 19 <u>84</u> <u>9-15</u> 19 <u>84</u> to <u>9-20</u> 19 <u>84</u> that (I) (we) lost the deceased alive on <u>9-20</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Dr. Depestre</u>		MD		9-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
R. DEPESTRE		BALTIMORE COUNTY GENERAL HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL	9/21/84	TIFERETH ISRAEL ANSHE SPARD		ROSEDALE BALTO. MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS., INC.		SEP 25 1984		<u>Davidson-Randall</u>	
6010 REISTERSTOWN RD. BALTO., MD 21215					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

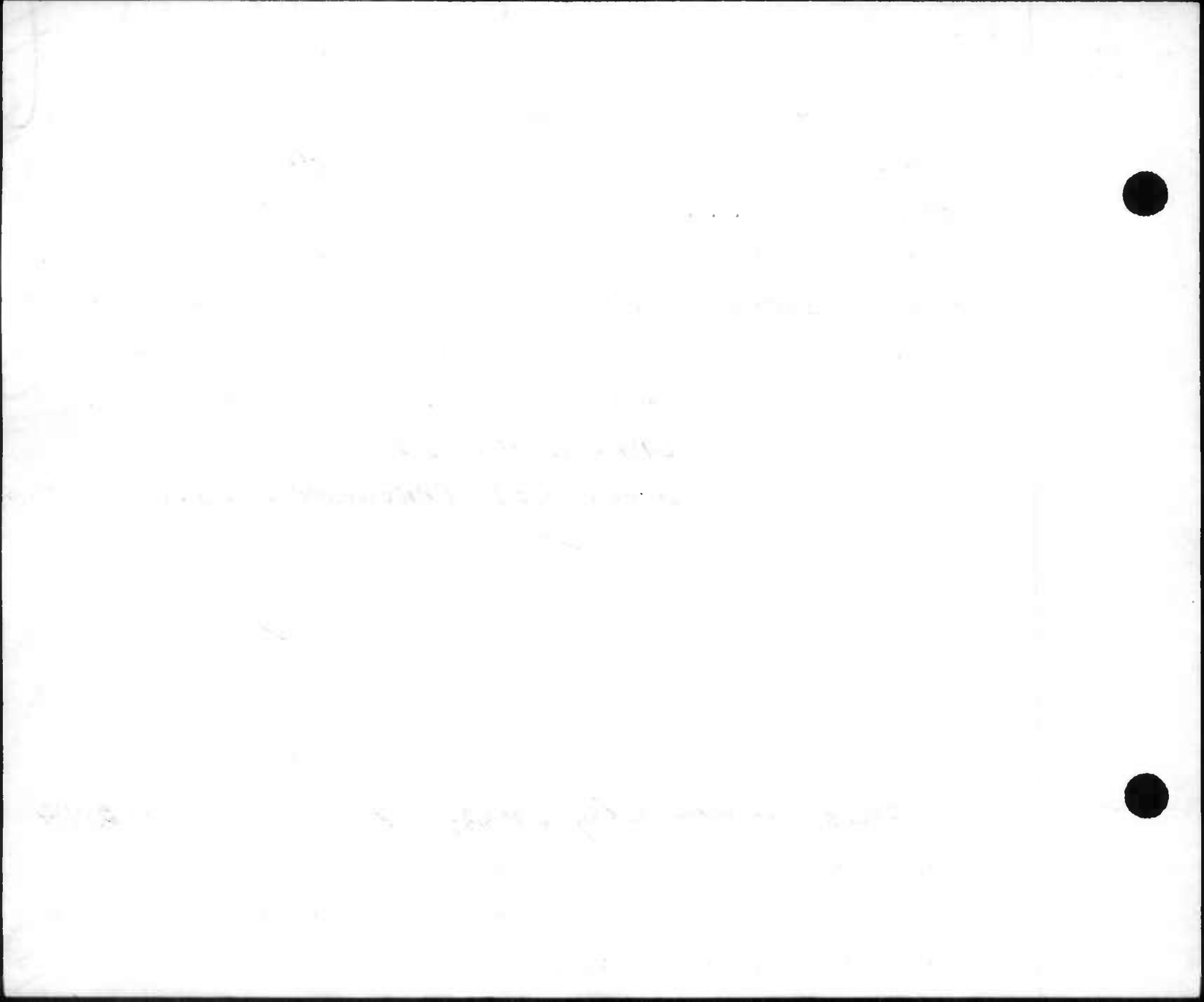
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Edward W. Leutner		Male		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
8 MONTH 6 DAY 1900		84 YRS.		Maryland	
8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		Baltimore County MD.		Westview	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
1024 Craftswood Road		Clerk		Railway Exp.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Carroll		Sykesville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Henry Leutner		Elizabeth Harian		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
714-05-6882		Walter H. Leutner		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>	
1024 Craftswood Rd.		21228		DUE TO, OR AS A CONSEQUENCE OF (b) <u>SMALL CELL CARCINOMA OF LUNG</u>	
				DUE TO, OR AS A CONSEQUENCE OF (c) <u>/</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Dr. Chopra</u> DEGREE <u>M.B.B.S.</u>	
22c. DATE SIGNED <u>9/28/84</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Dr. Chopra		St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10/1/84		Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Baltimore Maryland		Hubbard Funeral Home, Inc.		OCT 1 1984	
25b. REGISTRAR'S SIGNATURE <u>Gelia Davidson-Randall</u>		25c. REGISTRAR'S ADDRESS		25d. REGISTRAR'S PHONE NO.	
		4107 Wilkens Ave.			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

8 4 REG. NO. 2 3 6 7 3

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES A. LEWIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/25/84</b>		2b. HOUR <b>8:15PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 22, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N CHARLES ST GBMC</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Inland Oil &amp; Che</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Lutherville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2 Wendslow Place 21093</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Lewis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>203-20-7764</b>		17. INFORMANT ADDRESS <b>Betty J. Lewis - Same as #13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>END STAGE CONGESTIVE HEART FAILURE 35 DAYS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>8/20</b> , 19 <b>84</b> , to <b>9/25</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22a. SIGNATURE <b>Ref W Gwathmey</b>				22b. DATE SIGNED <b>9/25/84</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. R. FAWCETT</b>				22d. ADDRESS <b>GBMC</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-28-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Baltimore, Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
25a. DATE REC'D. BY REGISTRAR <b>SEP 27 1984</b>				25b. REGISTRAR'S SIGNATURE	

BP \_\_\_\_\_

Black Towson Funeral Home, Inc. Towson, Md. 21204  
1050 York Rd.  
Parkwood

Parkville, Baltimore, Maryland

Barisal

9-78-84

Parkwood

DR. P. FAWCETT

BY CARDINAL THEATRE

STATE CONFESSIVE HEART FAILURE 35 DAYS

No

203-20-7764 Betty J. Lewis - Same as #136

Alexander

Lewis

Saxton

Unknown

Maryland Baltimore Parkersville

N

2 Wendalaw Place 21023

T. J. J. J.

CLARK ST. BLDG

Truck Driver

Inland City & Ctn

Tennessee U.S.A.

BALTIMORE COUNTY

White

March 22, 1928

56

W. J. J. J.

1928

1928



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

4 2 3 6 7 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MOLLIE LIBERTO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 30, 1984</b>		2b. HOUR <b>9 A M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 20 1896</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>LUTHERVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1406 BELMORE COURT</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>LUTHERVILLE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>DR. JACOB LAZARUS 130 SLADE AVENUE APT 519</b>		
13e. STREET ADDRESS / ZIP CODE <b>1406 BELMORE COURT ( 21093)</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Hypertension

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 2nd 1959</u> to <u>Sept 30th 1984</u> , that (I) (we) saw the deceased alive on <u>Sept. 11th 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Kevin Quinn M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>OCTOBER 1, 1984</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. KEVIN QUINN</b>				22e. ADDRESS <b>1205 YORK ROAD, TOWSON, MD.</b>			

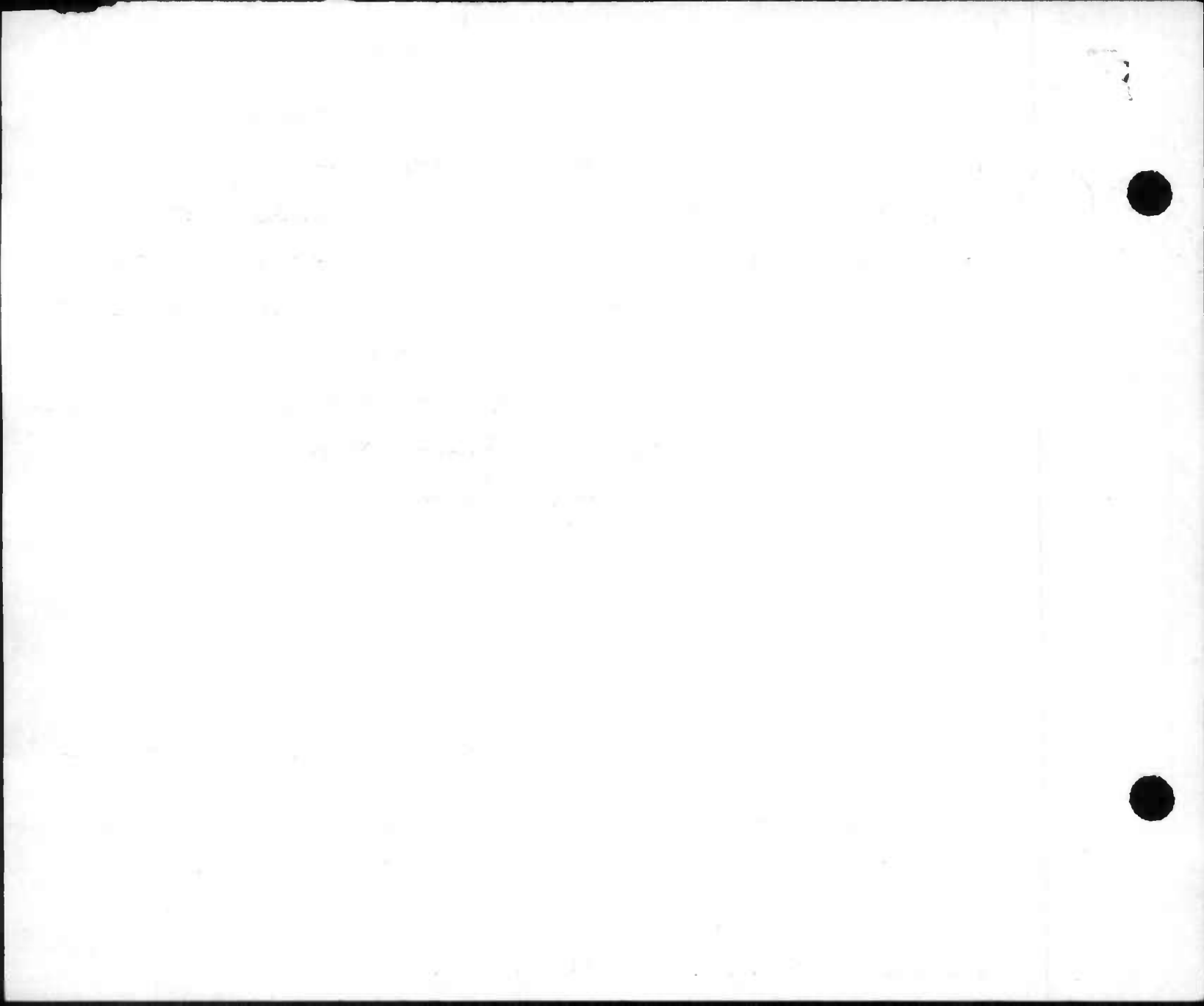
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>OCT. 1, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOE LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 3 1984</b>		25b. REGISTRAR'S SIGNATURE <u>Jane Wadsworth-Randall</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



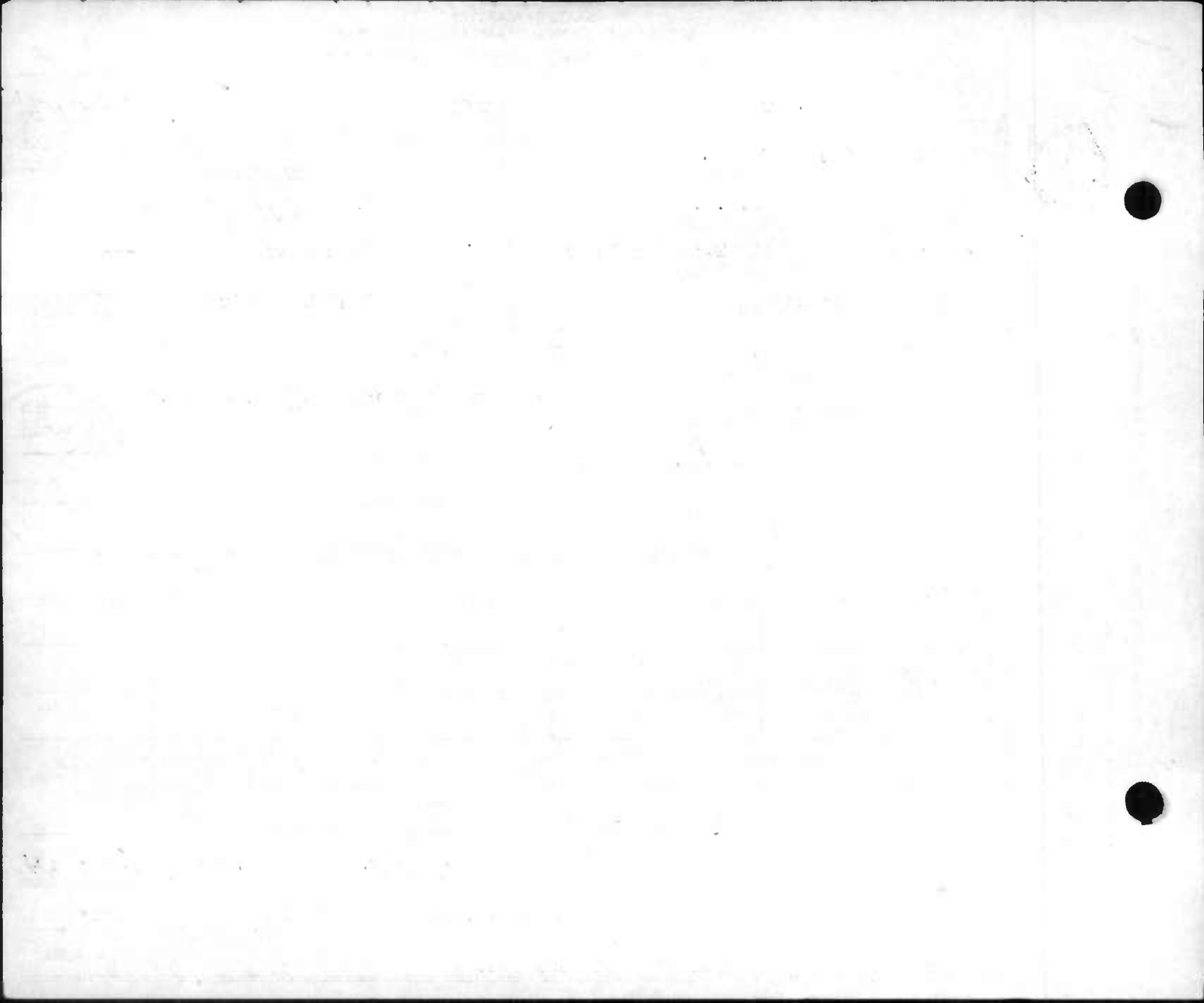
BP

DHMH: 17  
(VR A15 ME (S))  
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 1 HOUR AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23675	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET ROSA LITVIN						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 14 1984		2b. HOUR 11:45 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 30 13		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 71		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 14 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			2d. HOUR 11:45 PM		
10. CITY OR TOWN OF DEATH Lansdowne		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1422 Twin Circle Way 21227				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lansdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1422 Twin Circle Way 21227			
14. FATHER'S NAME FIRST MIDDLE LAST Wilbur C. Becker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian May Fleury							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) unavailable		17. INFORMANT ADDRESS Doris Martinez 107 E. Governors Court 21061					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E.P. Williamson				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT) E.P. Williamson				ADDRESS 5550 Barton Rd LK 21228							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229						25a. DATE REC'D. BY REGISTRAR SEP 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROY DANIEL LONG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-18-1984</b>		2b. HOUR <b>2:30 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-23-1931</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>53 yrs.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10 Taxiway</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>10 Taxiway Balto. 21220</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Long</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Plum</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>Korean 215-48-3863</b>		17. INFORMANT ADDRESS <b>Steven Long same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>depression</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Round Cell Carcinoma @ Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 minutes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 84</b> , to <b>18 Sept 84</b> , that (I) (we) last saw the deceased alive on <b>18 Sept 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>19 Sept 84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Henry Scagliola</b>				22e. ADDRESS <b>9712 Belair Road</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>9-21-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons City Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parsons, West Virg.</b>	
24. FUNERAL HOME, Inc. NAME ADDRESS <b>9705 Belair Road, Balto., Md. 21236</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 25 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP



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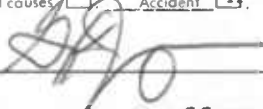

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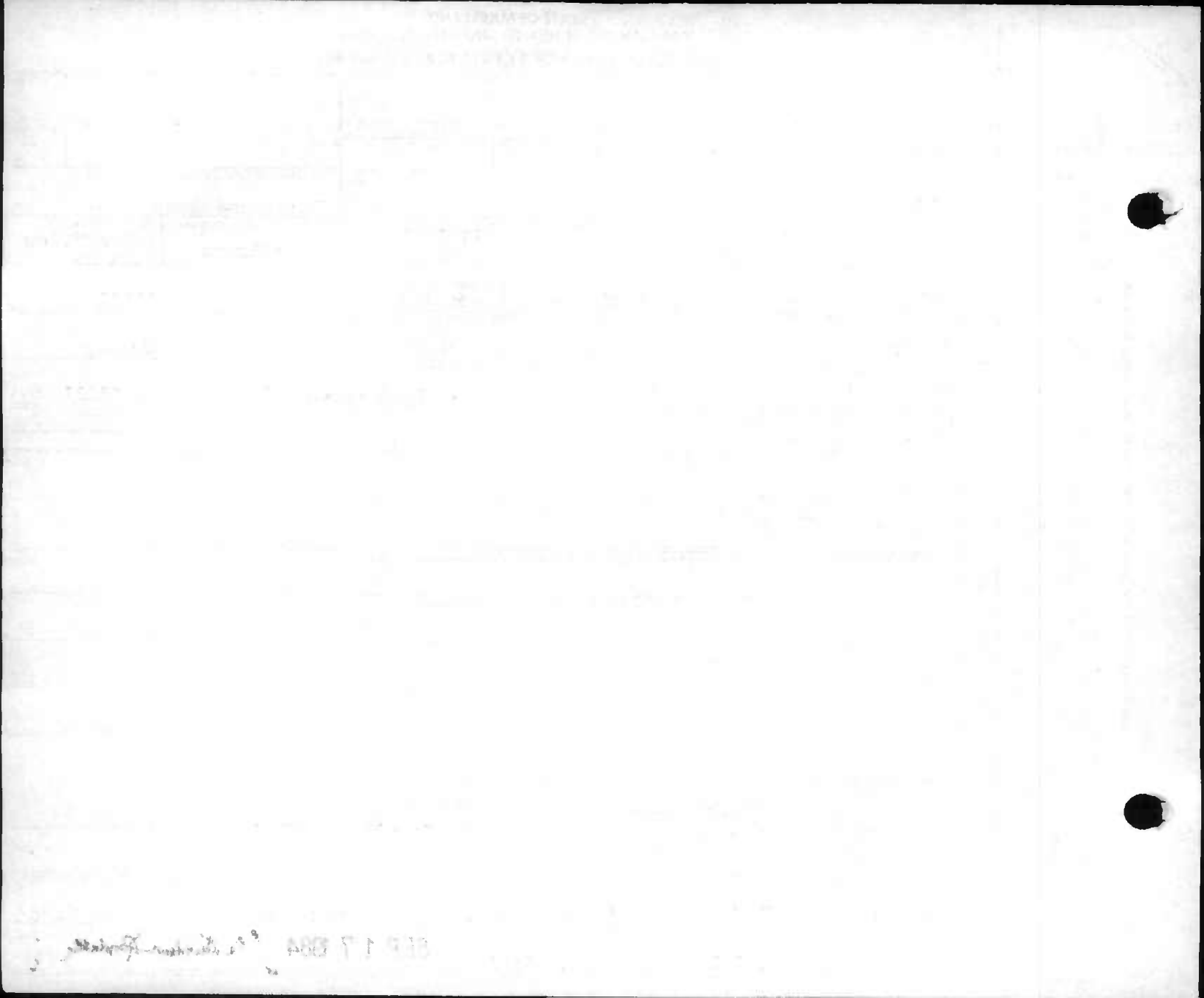


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Dawn Marie Lopez						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 9/13/84			2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 24 60		6. AGE (IN YEARS) (LAST BIRTHDAY) 24 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Essex			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21221 Intersection of Margaret & Virginia Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress			12b. KIND OF BUSINESS OR INDUSTRY Roland View Towers		
13a. STATE Maryland			13b. COUNTY ---			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 802 Union Avenue			13f. CITY OR TOWN 21211			14. FATHER'S NAME FIRST MIDDLE LAST Richard Lopez			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Greeley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---			17. INFORMANT Mrs. Hazel Lopez			ADDRESS 802 Union Ave. 21211		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> 8123 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:00xx 9/13/ 1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject occupant of motorcycle/auto collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Intersec. Margaret & Virginia Ave., BaltoCo., Md					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 9/13/84		
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St., Balto., Md 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/17/84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr.			ADDRESS 3818 Roland Ave. 21211			25a. DATE REC'D BY REGISTRAR SEP 17 1984			25b. REGISTRAR'S SIGNATURE 		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude Amelia Lorenz			2a. DATE OF DEATH MONTH DAY YEAR September 22, 1984		2b. HOUR 10:15 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Inglenook Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Reinhardt Lorenz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Fischer		13e. STREET ADDRESS 32 Dunvegan Road 21228	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 214-46-1838		17. INFORMANT Marie E. Walterhoefer Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Patrick W. White</u>		DEGREE M.D.		22c. DATE SIGNED 9/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick W. White		22e. ADDRESS 299 Frederick Rd. Catonsville, Md 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/24/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland					
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville, Md.		25a. DATE REC'D. BY REGISTRAR SEP 27 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DATE: 10/10/1964  
BY: J. H. HARRIS  
NO. 10 42472 1000

8

10/10/64

10/10/64

10/10/64

10/10/64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

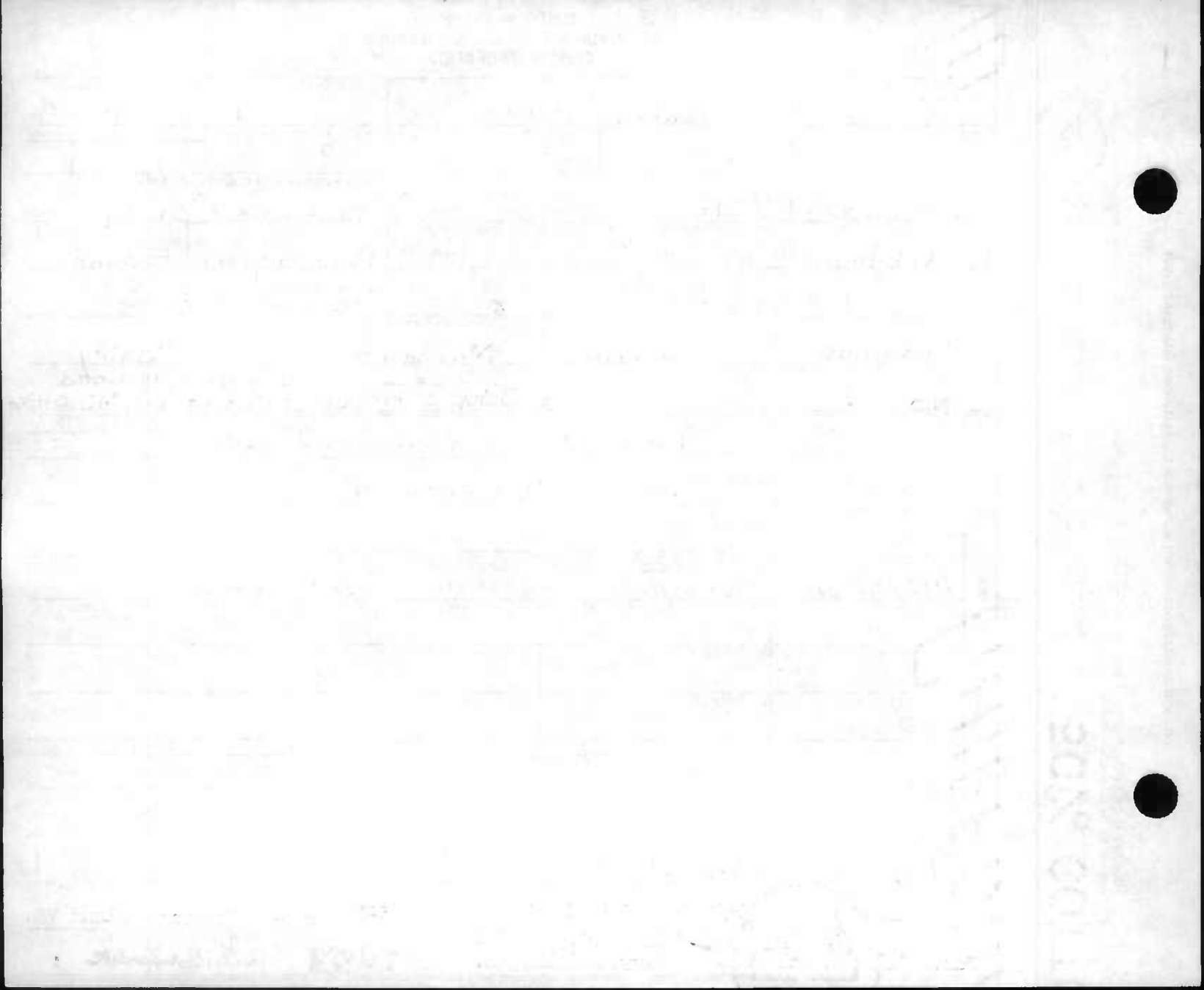
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH BENJAMIN LUCKHAM</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>3</b> YEAR <b>84</b>			2b. HOUR <b>1:30 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>07</b> DAY <b>02</b> YEAR <b>01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plant Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>REISTERSTOWN</b>		13c. CITY OR TOWN <b>REISTERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>604 Beverly Rd. RE 21136</b>	
14. FATHER'S NAME FIRST <b>Cadamus</b> MIDDLE <b>L</b> LAST <b>Luckham</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b>C</b> LAST <b>Conley</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>229-01-0495</b>		17. INFORMANT <b>John J. France</b> ADDRESS <b>604 Beverly Road REISTERSTOWN MD. 21136</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA. 2° SUB</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MANDIBULAR CARCINOMA.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASPIRATION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>NEUMONIA CONGESTIVE HEART FAILURE</b>									
19a. DATE OF OPERATION <b>9-3-84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ASPIRATION</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-14</b> 19 <b>84</b> , to <b>9-3</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9-3</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jasneem Lakhami MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>9/3/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JASNEEM LAKHAMANI MD</b>				22e. ADDRESS <b>5401 OLD COURT RD, RANDALLSTOWN MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/5/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairfields Bapt. Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Burgess</b> COUNTY <b>Northumberland</b> STATE <b>VA.</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>	
24. FUNERAL DIRECTOR NAME <b>Jones-Ash Funeral Home</b> ADDRESS <b>P.O. Box 276 Heathsville, VA.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or 100

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		M	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		Beatrice C. Luhrman		September 18, 1984			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		Nov. 19, 1903		80		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore, Md.		USA				Baltimore County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Essex 21221		2002 Golupski Rd.		Clerk		Engineering Co			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Baltimore		Essex		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2002 Golupski Rd. 21221	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
David Frederick Crowley		Henrietta Shaw		No		216 24 2146		David Luhrman, Son Same	
18. CAUSE OF DEATH		19. OTHER SIGNIFICANT CONDITIONS		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED		20c. DATE SIGNED	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>NORMAL PRESSURE HYDROCEPHALUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GASTRO INTESTINAL BLEEDING</u>		URINARY TRACT INFECTION, SEPTICEMIA		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		9-18-84	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY	
		HOUR A.M. MONTH DAY YEAR P.M. 19		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		TAT HOME STREET FACTORY, OFFICE FARM ETC.)	
21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE			
5400 OLD COURT ROAD RANDALLSTOWN MD 21133		Baltimore		Baltimore		Md.			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-14-</u> 19 <u>84</u> to <u>9-14-</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>9-14-84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
		M.D.		9-18-84		JAHANGIR M. KHAN		5400 OLD COURT ROAD RANDALLSTOWN MD 21133	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
Burial		9/21/84		Oak Lawn Cemetery		Baltimore Co., Md.		SEP 19 1984	
24. FUNERAL HOME		24b. ADDRESS		24c. CITY OR TOWN		24d. COUNTY		24e. STATE	
Brudzinski Funeral Home		1407 Old Eastern Ave		Baltimore		Md.			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

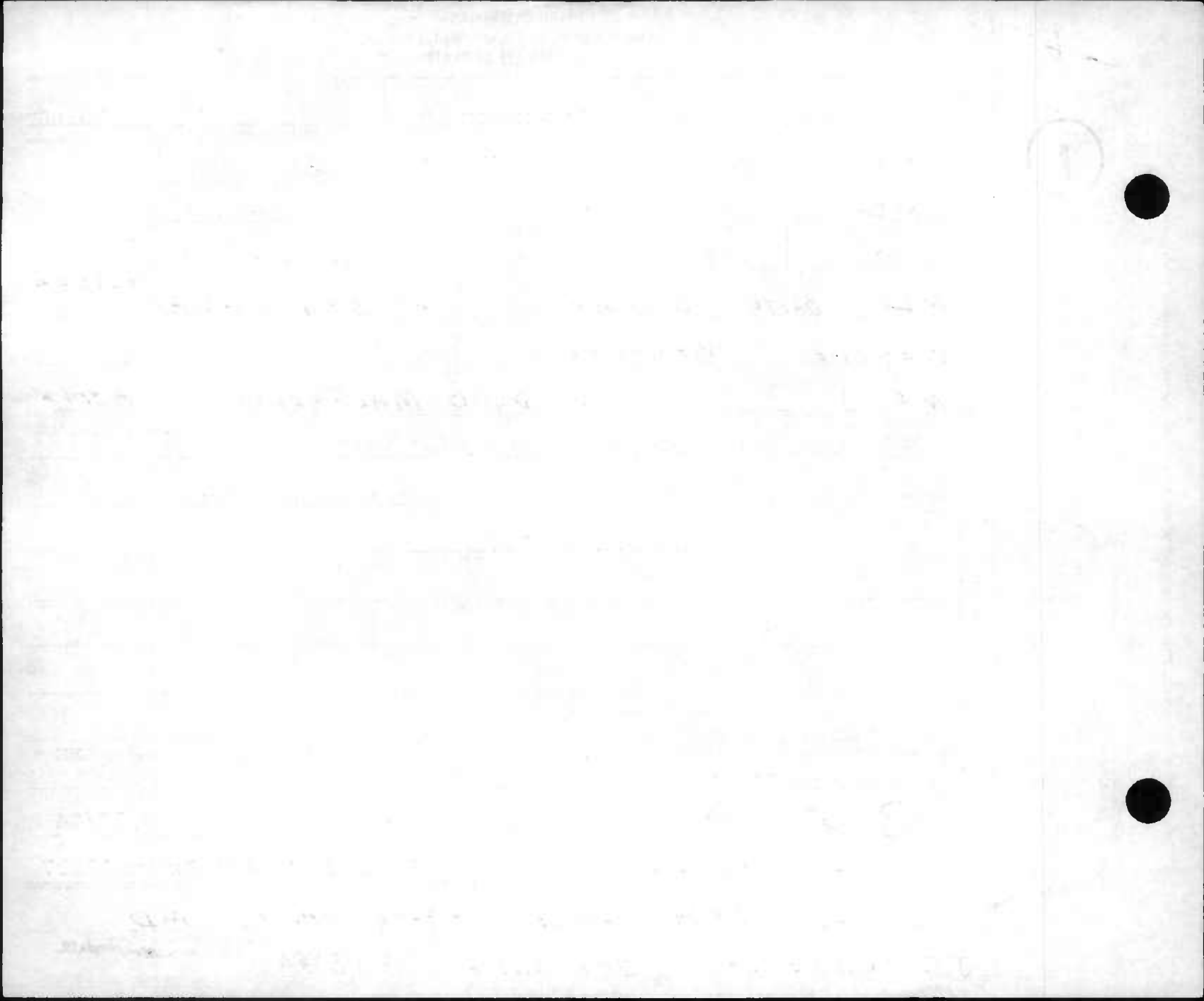
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/BI  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 23681							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ruth M MacGregor</b>					2a DATE OF DEATH MONTH DAY YEAR <b>9 11 84</b>		2b HOUR <b>10:00PM</b>		
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 31 14</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10 CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) <b>3106 Yorkway</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H S W F</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>MD.</b>		13b COUNTY <b>BALTO.</b>		13c CITY OR TOWN <b>DUNDALK</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>3106 YORKWAY</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE BEHRENS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Beck</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-01-0216</b>		17. INFORMANT ADDRESS <b>DAVID MACGREGOR ABOVE</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute &amp; chronic renal failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Advanced generalized Athereosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Milletus</b>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>6/10</b> , 19 <b>77</b> , to <b>present</b> , 19 <b>84</b> that (I) <b>xx</b> last saw the deceased alive on <b>9/11/84</b> , 19 <b>84</b> , and that in (my) <b>xx</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>xx</b> (did) <b>xx</b> view the body after death.									
22b SIGNATURE <b>David P. Zajano</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>9/12/84</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>David P. Zajano, M.D.</b>				22e ADDRESS <b>9000 Franklin Square Drive 21237</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>9/8/84</b>		23c NAME OF CEMETERY OR CREMATORY <b>GARDENS OF SAATH</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24 FUNERAL DIRECTOR NAME <b>J.G. CONNELLY</b>				ADDRESS <b>300 MACE</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>		25b REGISTRAR'S SIGNATURE <b>John Harrison Randall</b>	

MEDICAL CERTIFICATION





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will file notification on one of the following forms: (a) Form 100-1 (b) Form 100-2 (c) Form 100-3 (d) Form 100-4 (e) Form 100-5 (f) Form 100-6 (g) Form 100-7 (h) Form 100-8 (i) Form 100-9 (j) Form 100-10 (k) Form 100-11 (l) Form 100-12 (m) Form 100-13 (n) Form 100-14 (o) Form 100-15 (p) Form 100-16 (q) Form 100-17 (r) Form 100-18 (s) Form 100-19 (t) Form 100-20 (u) Form 100-21 (v) Form 100-22 (w) Form 100-23 (x) Form 100-24 (y) Form 100-25 (z) Form 100-26 (aa) Form 100-27 (ab) Form 100-28 (ac) Form 100-29 (ad) Form 100-30 (ae) Form 100-31 (af) Form 100-32 (ag) Form 100-33 (ah) Form 100-34 (ai) Form 100-35 (aj) Form 100-36 (ak) Form 100-37 (al) Form 100-38 (am) Form 100-39 (an) Form 100-40 (ao) Form 100-41 (ap) Form 100-42 (aq) Form 100-43 (ar) Form 100-44 (as) Form 100-45 (at) Form 100-46 (au) Form 100-47 (av) Form 100-48 (aw) Form 100-49 (ax) Form 100-50 (ay) Form 100-51 (az) Form 100-52 (ba) Form 100-53 (bb) Form 100-54 (bc) Form 100-55 (bd) Form 100-56 (be) Form 100-57 (bf) Form 100-58 (bg) Form 100-59 (bh) Form 100-60 (bi) Form 100-61 (bj) Form 100-62 (bk) Form 100-63 (bl) Form 100-64 (bm) Form 100-65 (bn) Form 100-66 (bo) Form 100-67 (bp) Form 100-68 (bq) Form 100-69 (br) Form 100-70 (bs) Form 100-71 (bt) Form 100-72 (bu) Form 100-73 (bv) Form 100-74 (bw) Form 100-75 (bx) Form 100-76 (by) Form 100-77 (bz) Form 100-78 (ca) Form 100-79 (cb) Form 100-80 (cc) Form 100-81 (cd) Form 100-82 (ce) Form 100-83 (cf) Form 100-84 (cg) Form 100-85 (ch) Form 100-86 (ci) Form 100-87 (cj) Form 100-88 (ck) Form 100-89 (cl) Form 100-90 (cm) Form 100-91 (cn) Form 100-92 (co) Form 100-93 (cp) Form 100-94 (cq) Form 100-95 (cr) Form 100-96 (cs) Form 100-97 (ct) Form 100-98 (cu) Form 100-99 (cv) Form 100-100 (cw) Form 100-101 (cx) Form 100-102 (cy) Form 100-103 (cz) Form 100-104 (da) Form 100-105 (db) Form 100-106 (dc) Form 100-107 (dd) Form 100-108 (de) Form 100-109 (df) Form 100-110 (dg) Form 100-111 (dh) Form 100-112 (di) Form 100-113 (dj) Form 100-114 (dk) Form 100-115 (dl) Form 100-116 (dm) Form 100-117 (dn) Form 100-118 (do) Form 100-119 (dp) Form 100-120 (dq) Form 100-121 (dr) Form 100-122 (ds) Form 100-123 (dt) Form 100-124 (du) Form 100-125 (dv) Form 100-126 (dw) Form 100-127 (dx) Form 100-128 (dy) Form 100-129 (dz) Form 100-130 (ea) Form 100-131 (eb) Form 100-132 (ec) Form 100-133 (ed) Form 100-134 (ee) Form 100-135 (ef) Form 100-136 (eg) Form 100-137 (eh) Form 100-138 (ei) Form 100-139 (ej) Form 100-140 (ek) Form 100-141 (el) Form 100-142 (em) Form 100-143 (en) Form 100-144 (eo) Form 100-145 (ep) Form 100-146 (eq) Form 100-147 (er) Form 100-148 (es) Form 100-149 (et) Form 100-150 (eu) Form 100-151 (ev) Form 100-152 (ew) Form 100-153 (ex) Form 100-154 (ey) Form 100-155 (ez) Form 100-156 (fa) Form 100-157 (fb) Form 100-158 (fc) Form 100-159 (fd) Form 100-160 (fe) Form 100-161 (ff) Form 100-162 (fg) Form 100-163 (fh) Form 100-164 (fi) Form 100-165 (fj) Form 100-166 (fk) Form 100-167 (fl) Form 100-168 (fm) Form 100-169 (fn) Form 100-170 (fo) Form 100-171 (fp) Form 100-172 (fq) Form 100-173 (fr) Form 100-174 (fs) Form 100-175 (ft) Form 100-176 (fu) Form 100-177 (fv) Form 100-178 (fw) Form 100-179 (fx) Form 100-180 (fy) Form 100-181 (fz) Form 100-182 (ga) Form 100-183 (gb) Form 100-184 (gc) Form 100-185 (gd) Form 100-186 (ge) Form 100-187 (gf) Form 100-188 (gg) Form 100-189 (gh) Form 100-190 (gi) Form 100-191 (gj) Form 100-192 (gk) Form 100-193 (gl) Form 100-194 (gm) Form 100-195 (gn) Form 100-196 (go) Form 100-197 (gp) Form 100-198 (gq) Form 100-199 (gr) Form 100-200 (gs) Form 100-201 (gt) Form 100-202 (gu) Form 100-203 (gv) Form 100-204 (gw) Form 100-205 (gx) Form 100-206 (gy) Form 100-207 (gz) Form 100-208 (ha) Form 100-209 (hb) Form 100-210 (hc) Form 100-211 (hd) Form 100-212 (he) Form 100-213 (hf) Form 100-214 (hg) Form 100-215 (hh) Form 100-216 (hi) Form 100-217 (hj) Form 100-218 (hk) Form 100-219 (hl) Form 100-220 (hm) Form 100-221 (hn) Form 100-222 (ho) Form 100-223 (hp) Form 100-224 (hq) Form 100-225 (hr) Form 100-226 (hs) Form 100-227 (ht) Form 100-228 (hu) Form 100-229 (hv) Form 100-230 (hw) Form 100-231 (hx) Form 100-232 (hy) Form 100-233 (hz) Form 100-234 (ia) Form 100-235 (ib) Form 100-236 (ic) Form 100-237 (id) Form 100-238 (ie) Form 100-239 (if) Form 100-240 (ig) Form 100-241 (ih) Form 100-242 (ii) Form 100-243 (ij) Form 100-244 (ik) Form 100-245 (il) Form 100-246 (im) Form 100-247 (in) Form 100-248 (io) Form 100-249 (ip) Form 100-250 (iq) Form 100-251 (ir) Form 100-252 (is) Form 100-253 (it) Form 100-254 (iu) Form 100-255 (iv) Form 100-256 (iw) Form 100-257 (ix) Form 100-258 (iy) Form 100-259 (iz) Form 100-260 (ja) Form 100-261 (jb) Form 100-262 (jc) Form 100-263 (jd) Form 100-264 (je) Form 100-265 (jf) Form 100-266 (jg) Form 100-267 (jh) Form 100-268 (ji) Form 100-269 (jj) Form 100-270 (jk) Form 100-271 (jl) Form 100-272 (jm) Form 100-273 (jn) Form 100-274 (jo) Form 100-275 (jp) Form 100-276 (jq) Form 100-277 (jr) Form 100-278 (js) Form 100-279 (jt) Form 100-280 (ju) Form 100-281 (jv) Form 100-282 (jw) Form 100-283 (jx) Form 100-284 (jy) Form 100-285 (jz) Form 100-286 (ka) Form 100-287 (kb) Form 100-288 (kc) Form 100-289 (kd) Form 100-290 (ke) Form 100-291 (kf) Form 100-292 (kg) Form 100-293 (kh) Form 100-294 (ki) Form 100-295 (kj) Form 100-296 (kk) Form 100-297 (kl) Form 100-298 (km) Form 100-299 (kn) Form 100-300 (ko) Form 100-301 (kp) Form 100-302 (kq) Form 100-303 (kr) Form 100-304 (ks) Form 100-305 (kt) Form 100-306 (ku) Form 100-307 (kv) Form 100-308 (kw) Form 100-309 (kx) Form 100-310 (ky) Form 100-311 (kz) Form 100-312 (la) Form 100-313 (lb) Form 100-314 (lc) Form 100-315 (ld) Form 100-316 (le) Form 100-317 (lf) Form 100-318 (lg) Form 100-319 (lh) Form 100-320 (li) Form 100-321 (lj) Form 100-322 (lk) Form 100-323 (ll) Form 100-324 (lm) Form 100-325 (ln) Form 100-326 (lo) Form 100-327 (lp) Form 100-328 (lq) Form 100-329 (lr) Form 100-330 (ls) Form 100-331 (lt) Form 100-332 (lu) Form 100-333 (lv) Form 100-334 (lw) Form 100-335 (lx) Form 100-336 (ly) Form 100-337 (lz) Form 100-338 (ma) Form 100-339 (mb) Form 100-340 (mc) Form 100-341 (md) Form 100-342 (me) Form 100-343 (mf) Form 100-344 (mg) Form 100-345 (mh) Form 100-346 (mi) Form 100-347 (mj) Form 100-348 (mk) Form 100-349 (ml) Form 100-350 (mm) Form 100-351 (mn) Form 100-352 (mo) Form 100-353 (mp) Form 100-354 (mq) Form 100-355 (mr) Form 100-356 (ms) Form 100-357 (mt) Form 100-358 (mu) Form 100-359 (mv) Form 100-360 (mw) Form 100-361 (mx) Form 100-362 (my) Form 100-363 (mz) Form 100-364 (na) Form 100-365 (nb) Form 100-366 (nc) Form 100-367 (nd) Form 100-368 (ne) Form 100-369 (nf) Form 100-370 (ng) Form 100-371 (nh) Form 100-372 (ni) Form 100-373 (nj) Form 100-374 (nk) Form 100-375 (nl) Form 100-376 (nm) Form 100-377 (nn) Form 100-378 (no) Form 100-379 (np) Form 100-380 (nq) Form 100-381 (nr) Form 100-382 (ns) Form 100-383 (nt) Form 100-384 (nu) Form 100-385 (nv) Form 100-386 (nw) Form 100-387 (nx) Form 100-388 (ny) Form 100-389 (nz) Form 100-390 (oa) Form 100-391 (ob) Form 100-392 (oc) Form 100-393 (od) Form 100-394 (oe) Form 100-395 (of) Form 100-396 (og) Form 100-397 (oh) Form 100-398 (oi) Form 100-399 (oj) Form 100-400 (ok) Form 100-401 (ol) Form 100-402 (om) Form 100-403 (on) Form 100-404 (oo) Form 100-405 (op) Form 100-406 (oq) Form 100-407 (or) Form 100-408 (os) Form 100-409 (ot) Form 100-410 (ou) Form 100-411 (ov) Form 100-412 (ow) Form 100-413 (ox) Form 100-414 (oy) Form 100-415 (oz) Form 100-416 (pa) Form 100-417 (pb) Form 100-418 (pc) Form 100-419 (pd) Form 100-420 (pe) Form 100-421 (pf) Form 100-422 (pg) Form 100-423 (ph) Form 100-424 (pi) Form 100-425 (pj) Form 100-426 (pk) Form 100-427 (pl) Form 100-428 (pm) Form 100-429 (pn) Form 100-430 (po) Form 100-431 (pp) Form 100-432 (pq) Form 100-433 (pr) Form 100-434 (ps) Form 100-435 (pt) Form 100-436 (pu) Form 100-437 (pv) Form 100-438 (pw) Form 100-439 (px) Form 100-440 (py) Form 100-441 (pz) Form 100-442 (qa) Form 100-443 (qb) Form 100-444 (qc) Form 100-445 (qd) Form 100-446 (qe) Form 100-447 (qf) Form 100-448 (qg) Form 100-449 (qh) Form 100-450 (qi) Form 100-451 (qj) Form 100-452 (qk) Form 100-453 (ql) Form 100-454 (qm) Form 100-455 (qn) Form 100-456 (qo) Form 100-457 (qp) Form 100-458 (qq) Form 100-459 (qr) Form 100-460 (qs) Form 100-461 (qt) Form 100-462 (qu) Form 100-463 (qv) Form 100-464 (qw) Form 100-465 (qx) Form 100-466 (qy) Form 100-467 (qz) Form 100-468 (ra) Form 100-469 (rb) Form 100-470 (rc) Form 100-471 (rd) Form 100-472 (re) Form 100-473 (rf) Form 100-474 (rg) Form 100-475 (rh) Form 100-476 (ri) Form 100-477 (rj) Form 100-478 (rk) Form 100-479 (rl) Form 100-480 (rm) Form 100-481 (rn) Form 100-482 (ro) Form 100-483 (rp) Form 100-484 (rq) Form 100-485 (rr) Form 100-486 (rs) Form 100-487 (rt) Form 100-488 (ru) Form 100-489 (rv) Form 100-490 (rw) Form 100-491 (rx) Form 100-492 (ry) Form 100-493 (rz) Form 100-494 (sa) Form 100-495 (sb) Form 100-496 (sc) Form 100-497 (sd) Form 100-498 (se) Form 100-499 (sf) Form 100-500 (sg) Form 100-501 (sh) Form 100-502 (si) Form 100-503 (sj) Form 100-504 (sk) Form 100-505 (sl) Form 100-506 (sm) Form 100-507 (sn) Form 100-508 (so) Form 100-509 (sp) Form 100-510 (sq) Form 100-511 (sr) Form 100-512 (ss) Form 100-513 (st) Form 100-514 (su) Form 100-515 (sv) Form 100-516 (sw) Form 100-517 (sx) Form 100-518 (sy) Form 100-519 (sz) Form 100-520 (ta) Form 100-521 (tb) Form 100-522 (tc) Form 100-523 (td) Form 100-524 (te) Form 100-525 (tf) Form 100-526 (tg) Form 100-527 (th) Form 100-528 (ti) Form 100-529 (tj) Form 100-530 (tk) Form 100-531 (tl) Form 100-532 (tm) Form 100-533 (tn) Form 100-534 (to) Form 100-535 (tp) Form 100-536 (tq) Form 100-537 (tr) Form 100-538 (ts) Form 100-539 (tt) Form 100-540 (tu) Form 100-541 (tv) Form 100-542 (tw) Form 100-543 (tx) Form 100-544 (ty) Form 100-545 (tz) Form 100-546 (ua) Form 100-547 (ub) Form 100-548 (uc) Form 100-549 (ud) Form 100-550 (ue) Form 100-551 (uf) Form 100-552 (ug) Form 100-553 (uh) Form 100-554 (ui) Form 100-555 (uj) Form 100-556 (uk) Form 100-557 (ul) Form 100-558 (um) Form 100-559 (un) Form 100-560 (uo) Form 100-561 (up) Form 100-562 (uq) Form 100-563 (ur) Form 100-564 (us) Form 100-565 (ut) Form 100-566 (uu) Form 100-567 (uv) Form 100-568 (uw) Form 100-569 (ux) Form 100-570 (uy) Form 100-571 (uz) Form 100-572 (va) Form 100-573 (vb) Form 100-574 (vc) Form 100-575 (vd) Form 100-576 (ve) Form 100-577 (vf) Form 100-578 (vg) Form 100-579 (vh) Form 100-580 (vi) Form 100-581 (vj) Form 100-582 (vk) Form 100-583 (vl) Form 100-584 (vm) Form 100-585 (vn) Form 100-586 (vo) Form 100-587 (vp) Form 100-588 (vq) Form 100-589 (vr) Form 100-590 (vs) Form 100-591 (vt) Form 100-592 (vu) Form 100-593 (vv) Form 100-594 (vw) Form 100-595 (vx) Form 100-596 (vy) Form 100-597 (vz) Form 100-598 (wa) Form 100-599 (wb) Form 100-600 (wc) Form 100-601 (wd) Form 100-602 (we) Form 100-603 (wf) Form 100-604 (wg) Form 100-605 (wh) Form 100-606 (wi) Form 100-607 (wj) Form 100-608 (wk) Form 100-609 (wl) Form 100-610 (wm) Form 100-611 (wn) Form 100-612 (wo) Form 100-613 (wp) Form 100-614 (wq) Form 100-615 (wr) Form 100-616 (ws) Form 100-617 (wt) Form 100-618 (wu) Form 100-619 (wv) Form 100-620 (ww) Form 100-621 (wx) Form 100-622 (wy) Form 100-623 (wz) Form 100-624 (xa) Form 100-625 (xb) Form 100-626 (xc) Form 100-627 (xd) Form 100-628 (xe) Form 100-629 (xf) Form 100-630 (xg) Form 100-631 (xh) Form 100-632 (xi) Form 100-633 (xj) Form 100-634 (xk) Form 100-635 (xl) Form 100-636 (xm) Form 100-637 (xn) Form 100-638 (xo) Form 100-639 (xp) Form 100-640 (xq) Form 100-641 (xr) Form 100-642 (xs) Form 100-643 (xt) Form 100-644 (xu) Form 100-645 (xv) Form 100-646 (xw) Form 100-647 (xx) Form 100-648 (xy) Form 100-649 (xz) Form 100-650 (ya) Form 100-651 (yb) Form 100-652 (yc) Form 100-653 (yd) Form 100-654 (ye) Form 100-655 (yf) Form 100-656 (yg) Form 100-657 (yh) Form 100-658 (yi) Form 100-659 (yj) Form 100-660 (yk) Form 100-661 (yl) Form 100-662 (ym) Form 100-663 (yn) Form 100-664 (yo) Form 100-665 (yp) Form 100-666 (yq) Form 100-667 (yr) Form 100-668 (ys) Form 100-669 (yt) Form 100-670 (yu) Form 100-671 (yv) Form 100-672 (yw) Form 100-673 (yx) Form 100-674 (yy) Form

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 5 8 3

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Elizabeth M. Magee</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Sept. 24, 1984</i>			2b. HOUR <i>4:00P.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-18-17</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1917 Ellinwood Road -21237</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Saleslady</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i> 13c. COUNTY <i>Balto.</i> 13d. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE <i>1917 Ellinwood Road-21237</i>				
14. FATHER'S NAME FIRST <i>Louis A.</i> MIDDLE <i>Wiseman</i> LAST			15. MOTHER'S MAIDEN NAME FIRST <i>Elizabeth</i> MIDDLE <i>Muth</i> LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-16-5404</i>		17. INFORMANT ADDRESS <i>Mr. Thomas F. Magee - 1917 Ellinwood Rd. Balto. Md. -21237</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>Carcinoma of the Breast with</i> DUE TO, OR AS A CONSEQUENCE OF <i>Brain metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Pt. Recently Discharged from Hosp.</i> that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert A. Hartley, MD</i> DEGREE						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert A. Hartley</i>						22e. ADDRESS <i>Union Memorial Hosp.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9-27-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd.-21206</i> ADDRESS						25a. DATE REC'D. BY REGISTRAR <i>SEP 26 1984</i> 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked *at home*, it is the duty of the medical examiner to be notified at death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 6 8 4

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Helen E. Mahaffey			2a. DATE OF DEATH MONTH DAY YEAR 9 25 84			2b. HOUR 12:30pm			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 03 1885		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.D.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD			
10. CITY OR TOWN OF DEATH Ridgelytown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7500 Brook Lane 21208	
14. FATHER'S NAME FIRST MIDDLE LAST Francis I. Foreman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Barton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-8615		17. INFORMANT ADDRESS Theresa Mahaffey 3723 Roland Ave, 21211					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive upper G.I. bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Bleeding duodenal ulcer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9-20 19 84, to 9-25 19 84, that (I) (we) lost saw the deceased alive on 9-25 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lovelinda Cheng, M.D.					DEGREE Pathologist ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lovelinda Cheng, M.D.					22e. ADDRESS Balt. County Gen. Hosp.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/28/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Burgee Funeral Home, 3631 Falls Road 21211					25a. DATE REC'D. BY REGISTRAR SEP 28 1984		25b. REGISTRAR'S SIGNATURE Lila Davidson-Randall		

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page 1

March 17 1947

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March 17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>Genevieve Malone</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>September 23 84</b>		2b. HOUR M	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 9 1999</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>TOWSON NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>723 Idlewild Rd Baltimore 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>BIALZAK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EUGENE WESZKA 723 Idlewild Rd</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>EUGENE WESZKA 723 Idlewild Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Senile Dementia, SP compression fx L2 Jewett Brace</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>10/17 1983</b> , to <b>9/23 1984</b> , that (I) (we) lost saw the deceased alive on <b>9/23 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true, read) I did not view the body after death.									
22b. SIGNATURE <b>Charles O'Donnell</b>				22c. DATE SIGNED <b>9/23/84</b>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles O'Donnell</b>	
22e. ADDRESS <b>7501 York Rd, Towson Md. 21204</b>				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>9/27/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Belair Mem Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Belair Md</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>KACZYNSKI FUNERAL HOME 3525 EKET STREET</b>				25. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>		25b. REGISTRAR'S SIGNATURE <b>a. Davidson-Randall</b>			

MEDICAL CERTIFICATION

1



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Nicholas</b>			MIDDLE <b>MANGIONE , SR</b>			2a. DATE OF DEATH MONTH <b>SEPTEMBER</b> DAY <b>17</b> YEAR <b>1984</b>			2b. HOUR <b>2:23</b> P <b>M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>18</b> YEAR <b>1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>BALTIMORE COUNTY</b> MD.							
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Maintenance</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Md.</b>						13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3432 Erdman Ave. 21213</b>	
14. FATHER'S NAME FIRST <b>Nicholas</b> MIDDLE <b></b> LAST <b>Mangione</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Carmella</b> MIDDLE <b></b> LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-10-0810</b>		17. INFORMANT ADDRESS <b>Fannie C. Mangione, Same as 13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROGRESSIVE RENAL FAILURE, HYPERTENSION, DEHYDRATION,</b> DUE TO OR AS A CONSEQUENCE OF <b>DIGOXIN TOXICITY.</b> (b) <b>SUPRAVENTRICULAR TACHYCARDIA.</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, PERMANENT PACEMAKER</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>STATUS POST MULTIPLE STROKES, SEIZURE DISORDER.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 4, 1984</b> to <b>SEPTEMBER 17, 1984</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>SEPTEMBER 17, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.													
22b. SIGNATURE <b>N. Okun, MD</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>9/17/84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. NINA OKUN, MD</b>						22e. ADDRESS <b>9000 FRANKLIN SQUARE DR., 21237</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9-20-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>			23d. LOCATION CITY OR TOWN <b>Balto., Md.</b> COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1984</b>		25b. REGISTRAR'S SIGNATURE <b>a. Davidson-Randall</b>					

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must be notified of at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. EXECUTE PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
<div style="display: flex; justify-content: space-between;"> <div> <p>1. DECEASED NAME (TYPE OR PRINT) FIRST MARY R. MIDDLE LAST MANN</p> <p>2. SEX Female</p> <p>3. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy</p> <p>10. CITY OR TOWN OF DEATH Towson</p> <p>13a. STATE Maryland</p> <p>14. FATHER'S NAME FIRST MIDDLE LAST Paolo Tana</p> <p>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No</p> <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carotid Artery</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>ASCAVD</u> (b) <u>ASCAVD</u> (c) <u>ASCAVD</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: IT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).</p> </div> <div> <p>4. RACE White</p> <p>5. DATE OF BIRTH (MONTH DAY YEAR) Nov. 3, 1907</p> <p>6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.</p> <p>7b. CITIZEN OF WHAT COUNTRY? U.S.A.</p> <p>11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital</p> <p>13b. COUNTY Baltimore</p> <p>13c. CITY OR TOWN Baltimore</p> <p>15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Consiglia Tana</p> <p>16b. SOCIAL SECURITY NO. 216-54-7194</p> <p>17. INFORMANT ADDRESS Pasquale Manna 1614 Ingram Road</p> </div> <div> <p>7a. DATE KNOWN OF DEATH ESTI- MATED Sept 10 1984 3 PM</p> <p>7c. DATE PRONOUNCED DEAD Sept 10 1984 3 PM</p> <p>9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.</p> <p>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife</p> <p>12b. KIND OF BUSINESS OR INDUSTRY</p> <p>13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>13e. STREET ADDRESS 1614 Ingram Road 21239</p> </div> </div>											
<p>19a. DATE OF OPERATION 9/10/84</p> <p>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Abscess of middle lobe Rthlung</p> <p>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR PRIMARY CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</p> <p>21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9 10 1984</p> <p>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) bled after puncture of pulmonary artery during surgery</p> <p>21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/></p> <p>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) NA Hospital</p> <p>21f. LOCATION (CITY OR TOWN, COUNTY, STATE) Towson, Baltimore Md.</p> <p>22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>.</p> <p>22b. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>.</p> <p>23a. BURIAL, CREMATION, REMOVAL (RECEIVED) Entombment</p> <p>23b. DATE Sept. 14, 1984</p> <p>23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Mausoleum</p> <p>23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Baltimore Maryland</p> <p>24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Maryland</p> <p>25a. DATE REC'D. BY REGISTRAR SEP 13 1984</p> <p>25b. REGISTRAR'S SIGNATURE John Davidson</p>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HAZEL HORNE MARCELLUS</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>10</b> YEAR <b>84</b>			2b. HOUR <b>12:15 PM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>25</b> YEAR <b>14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2005 Braddish Ave. Baltimore, Md. 21216</b>	
14. FATHER'S NAME FIRST <b>Dock</b> MIDDLE <b>Horne</b> LAST <b>Carrie</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Carrie</b> MIDDLE <b>Mc Cain</b> LAST <b>Mc Cain</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>			
16a. SOCIAL SECURITY NO. <b>239-36-5680</b>			17. INFORMANT <b>Sallie H. Russell</b>			17a. ADDRESS <b>1008 N. Bentalou Street Baltimore, Md. 21216</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **RESPIRATORY FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **METASTATIC LUNG DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
**8 months**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-29</b> , <b>84</b> , to <b>9-10</b> , <b>84</b> , that (I) (we) last saw the deceased alive on <b>9-10</b> , <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>I. O'Donnell</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (NAME OR PRINT) <b>I. O'DONNELL</b>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/14/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Nutter &amp; Sons</b> ADDRESS <b>2501 Gwynns Falls Parkway</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1984</b>			
Funeral Home Inc. Baltimore, Maryland 21216				REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
PATIENCE C. MARCUS		9 3 84		4 <sup>30</sup> A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	WHITE	MONTH DAY YEAR	90	IF UNDER 24 HRS.	
		2 25 94	90 YRS	MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia	U.S.A.			Baltimore County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville	Meridian (Catonsville) 16 Fursting Ave	Seamstress		Factory	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Catonsville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	932 Prestwood Road 21228	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	ADDRESS			
James B. Marcus	Ida A. V. Trenary	Doris Kerns 932 Prestwood Rd. 21228			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
NO	227-22-0167	Doris Kerns 932 Prestwood Rd. 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a): <i>Renal Distress</i>					
DUE TO, OR AS A CONSEQUENCE OF (b): <i>MI - 2067 NO.?</i>					
DUE TO, OR AS A CONSEQUENCE OF (c):					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M.			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from <i>8-28-84</i> 19 <i>84</i> to <i>9-3-84</i> 19 <i>84</i> , that (I) (we) lost sight of the deceased alive on <i>8-28-84</i> 19 <i>84</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
<i>George H. Nov</i>				<i>9-3-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
GEORGE H. NOV				3350 Wilkens Dr. Balt.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9/6/84		Ebenezer Cemetery	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
Bloomfield				Virginia	
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Hubbard Funeral Home, Inc.		4107 Wilkens Ave. 21229		SEP 4 1984	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			
		<i>Julia Davidson-Randall</i>			

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26





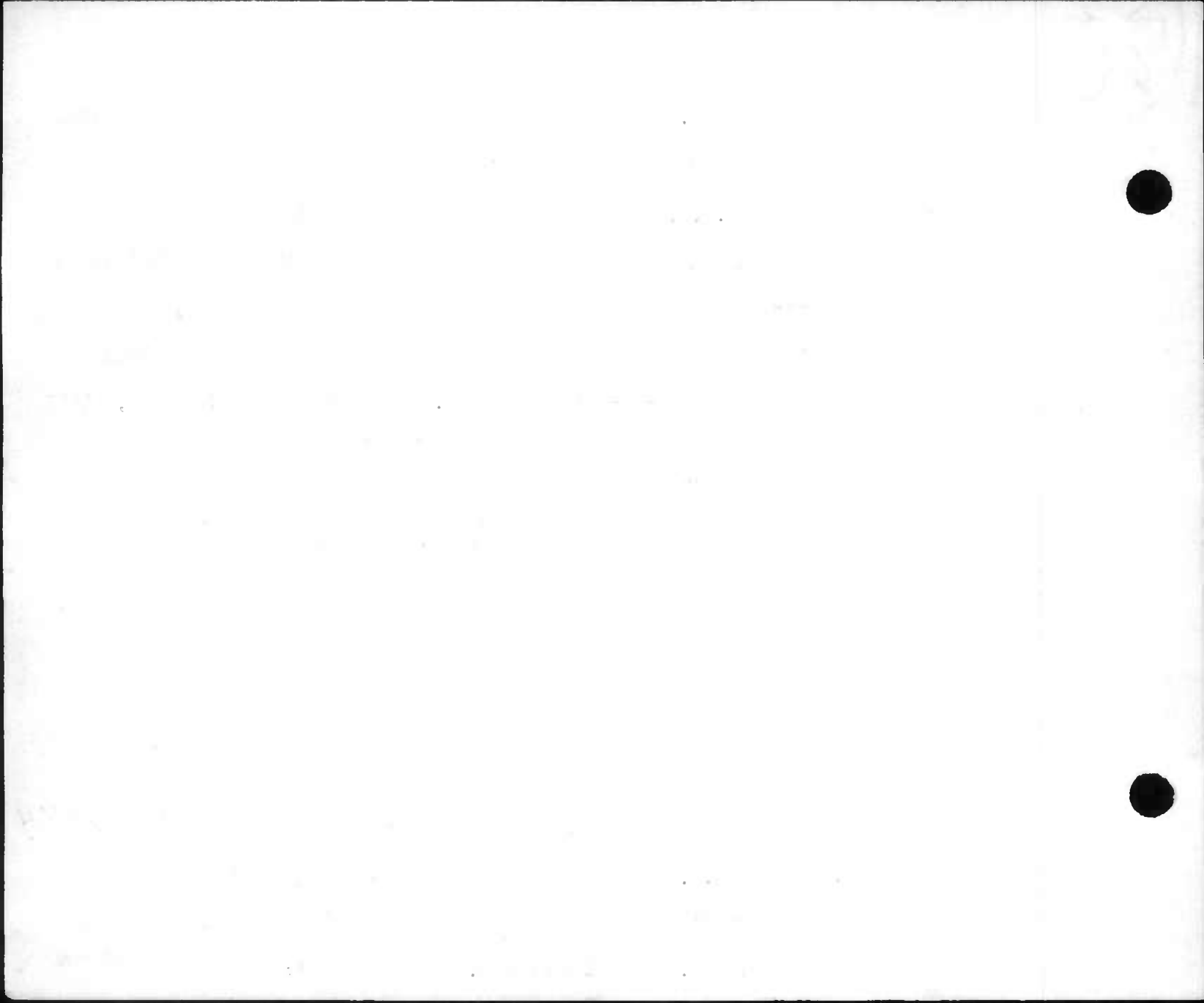
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CLARA FOREE MARINO</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>09 07 84</b>		2b. HOUR <b>2:30A M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 29 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FREDERICK VILLA NURSING CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>915 CALWELL ROAD, 21229</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN EDWARD KUHL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GRACE BUSH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-05-1660</b>		17. INFORMANT ADDRESS <b>CRAIG E. MARINO 1252 LOCUST AVENUE, 21227</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic cardiomyopathy</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>June 82</i> to <i>7 Sept 84</i> , that (I) (we) last saw the deceased alive on <i>7 Sept 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William J. Bryson M.D.</i> DEGREE 22c. DATE SIGNED <i>7 Sept 84</i>						22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM J. BRYSON, M.D.</b>						22g. ADDRESS <b>5772 WESTVIEW MALL, 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>09-10-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>					
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>						ADDRESS <b>21229 4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Randall</i>	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY JOSEPH MASLOWSKI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09-01-84</b>			2b. HOUR MIN. <b>5:25 P</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08-19-17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		7. YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Wisconsin</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE) <b>Administrator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
13a. STATE <b>Wisconsin</b>		13b. COUNTY <b>Milwaukee</b>		13c. CITY OR TOWN <b>GREENFIELD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3727 W. Ramsay Ave 53221</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Zygmunt Maslowski</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Lyskawinski</b>			16. ADDRESS <b>703 W. Lincoln Ave. 53215</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>		16c. <b>395-07-4431</b>		17. INFORMANT <b>Rozga Funeral Home Milwaukee, Wisconsin</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT, MASSIVE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>SEPSIS; GASTROINTESTINAL BLEED</b>									
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>08-22-84</b> to <b>09-01-84</b> , that (I) (we) last saw the deceased alive on <b>09-01-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Cesar Gambora M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9-1-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CESAR G. GAMBORA, MD</b>						22e. ADDRESS <b>3440 BELAIR ROAD BALTIMORE, MD 21213</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-5-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Adalbert Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Milwaukee Wisconsin</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 5 1984</b>	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>					25. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>				

100-43-1000

INVESTIGATION

REPORT

DATE

100-43-1000

10-11-17

WHITE

MALE

100-43-1000

10-11-17

MALE

100-43-1000 10-11-17 WHITE MALE 100-43-1000 10-11-17 WHITE MALE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

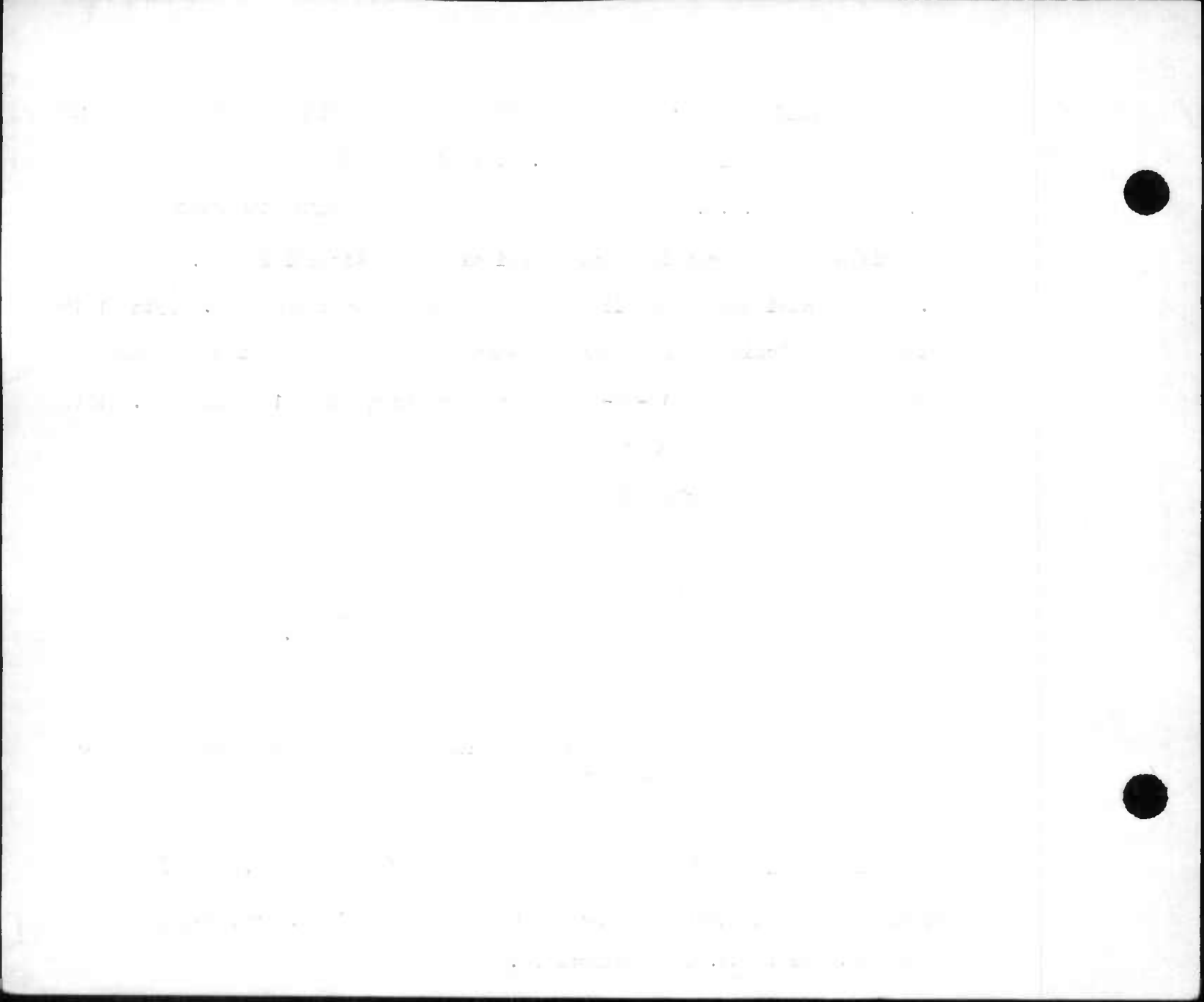
REG. NO.

1 - FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Nellie I. MASSEY		Female		White	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
Nov. 6, 1893		90		Md.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		Baltimore City		Rossville	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Franklin Square Hospital		Advertising Ex.			
13a STATE		13b COUNTY		13c CITY OR TOWN	
Md.		Baltimore		Rossville	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Walter Louis Iardella		Anna Phister Lynch		13e STREET ADDRESS / ZIP CODE	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		212-03-5824		Mary Margaret Funk 2107 Boone St. 21218	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septisemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Decubitus Ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>September 12</u> 19 <u>84</u> to <u>September 21</u> 19 <u>84</u> that <del>we</del> (we) last saw the deceased alive on <u>September 21</u> 19 <u>84</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>Keith English</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		9/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Keith English, MD		9000 Franklin Square Dr., 21237			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9/24/84		Loudon Park	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Baltimore, Maryland					
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Leonard J. Ruck, Inc.		5305 Harford Rd.		SEP 24 1984	
				25b. REGISTRAR'S SIGNATURE	
				<i>Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

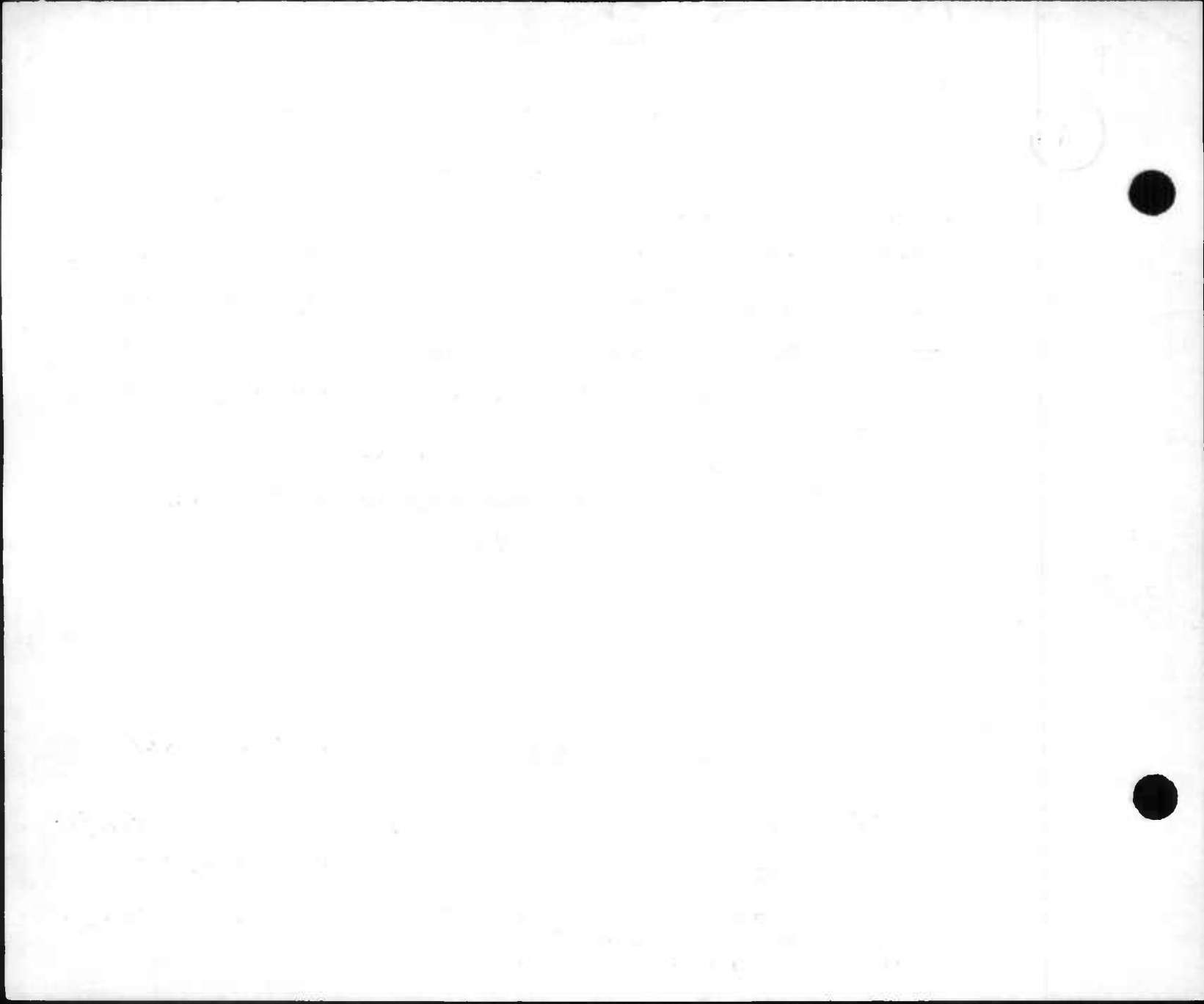
DHMM - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 6 9 3

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
PEARIS WATSON MASSIE		SEPTEMBER 8 1984		6 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	CAUCASIAN	FEB. 2 1900	84 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
W. VA.	U.S.A.		BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	MANOR CARE-ROSSVILLE	ANIMAL KEEPER	BALTO. ZOO		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	BALTO.	BALTIMORE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	6 PERHALL CT. 21236	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
PEARIS W. MASSIE		FLORENCE LILLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO		232-01-9571	EMMA MASSIE (WIFE) SAME ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Cardiac Respiratory failure</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary heart failure + fibrillation</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCD</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 3</i> 19 <i>84</i> to <i>Sept 8</i> 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>Sept 3</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>J. M. TOS</i>				<i>9/10/84</i>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS		23c. DATE REC'D. BY REGISTRAR	
DR. MA TOS		14 AIRWAY CIRCLE APT. 3-D		SEP 14 1984	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
REMOVAL		9/10/84	ATHENS CEMETERY	ATHENS-MERCER CO. W.VA.	
24. FUNERAL DIRECTOR'S NAME					
Schimunek Funeral Home, Inc. 9705 Belair Rd, 21236					
25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
SEP 14 1984				<i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

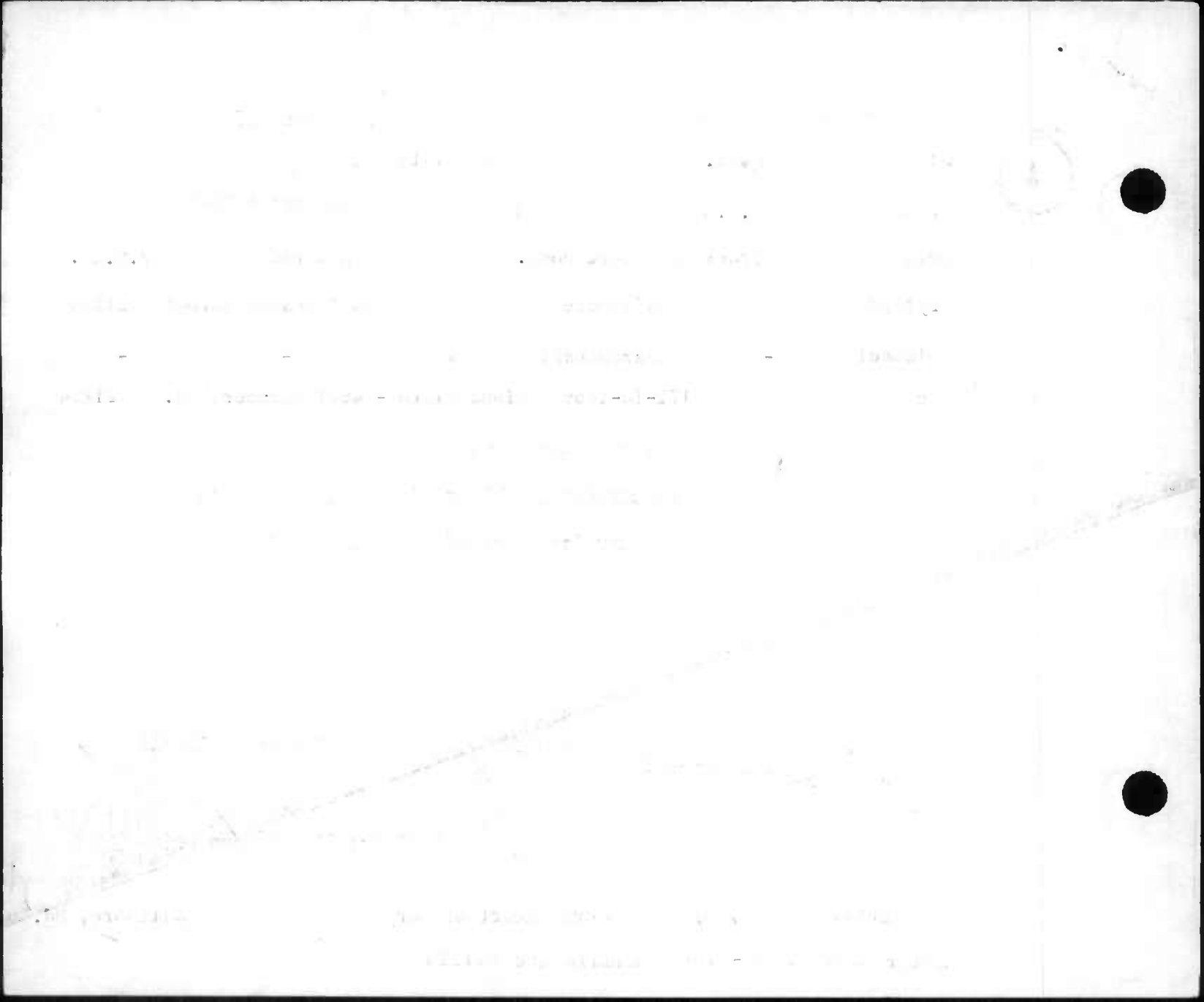
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23094

1. DECEASED NAME (TYPE OR PRINT) Victor M. MASZON			2a. DATE OF DEATH MONTH DAY YEAR September 17, 1984		2b. HOUR 11:01am	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 9 8 1915		
6. AGE (IN YEARS LAST BIRTHDAY) 69		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD				
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
12b. KIND OF BUSINESS OR INDUSTRY B.S.Co.						
13a. STATE Maryland		13b. COUNTY ✓		13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6608 Bushey Street #21224				
14. FATHER'S NAME FIRST MIDDLE LAST Michael - Maszczenski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva -				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 171-10-1469		17. INFORMANT ADDRESS Linda Plato - 4621 Harcourt Rd. #21224		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of lung with pleural effusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>s/p Myocardial Infarction on August 20, 1984</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 20, 1984, to September 17, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 17, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.						
22b. SIGNATURE J. Quansah		DEGREE M.D.		22c. DATE SIGNED 9/17/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) QUANSAH		22e. ADDRESS 9000 Franklin Square Drive 21237 FRANKLIN SQUARE HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/20/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.						
24. FUNERAL DIRECTOR NAME Walter Dabrowski - 1005 Dundalk Ave #21224				25a. DATE REC'D. BY REGISTRAR SEP 21 1984		
				25b. REGISTRAR'S SIGNATURE Davidson-Randall		

BP



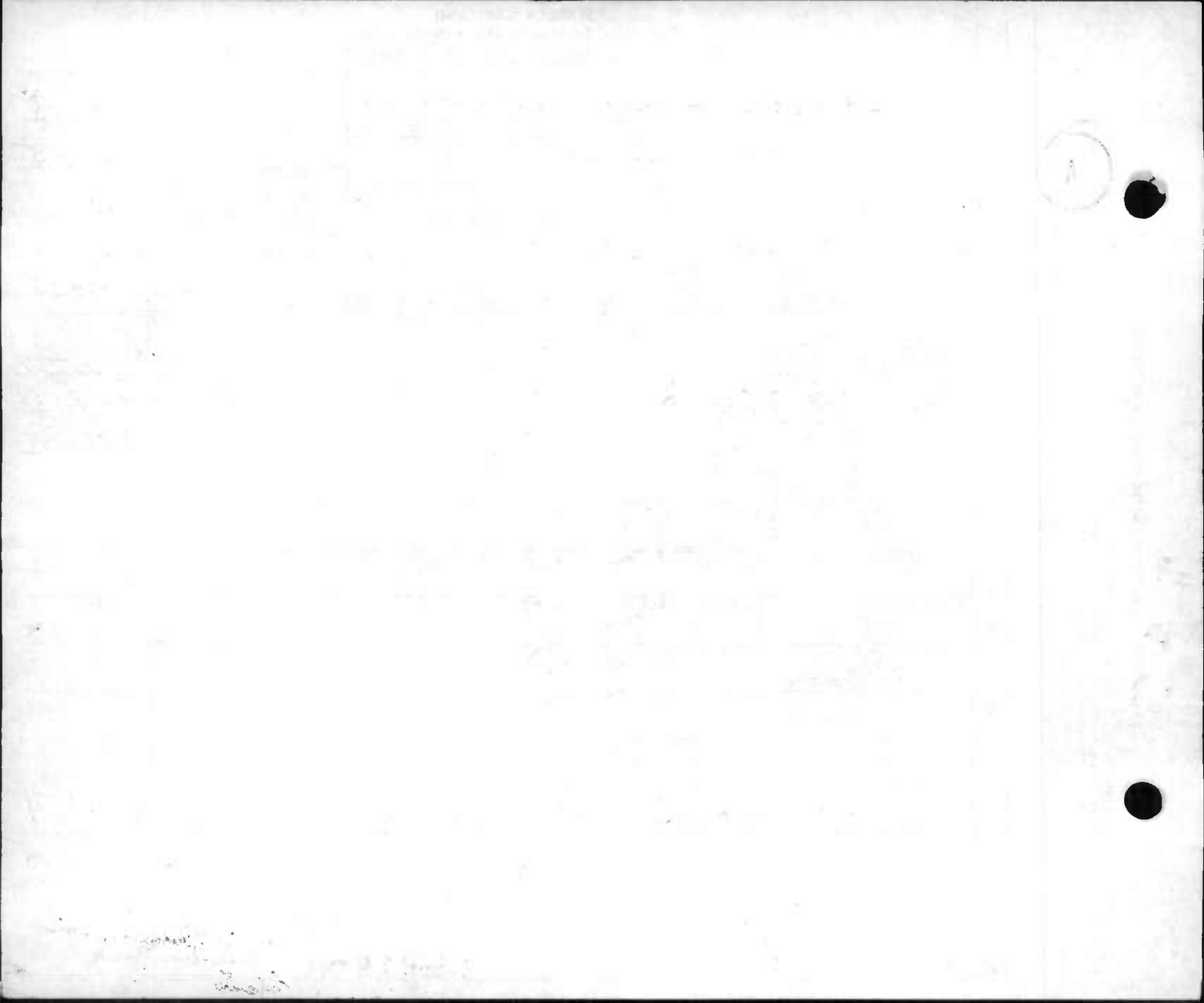
1. DECEASED NAME (TYPE OR PRINT) <b>LAWRENCE AUGUSTUS MATHEWS, SR</b>		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> 9 DAY 13 YEAR 1984		2b. HOUR 42 M	
3. SEX <b>M</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 10 1925</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>59 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	7. IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.B.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO County</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO County</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO County</b>	
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>409 DELLA AVE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISABLED</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>SERVICE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SERVICE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SERVICE</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>CATONSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>409 DELLA AVE. 21228</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE ALBERT MATTHEWS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE LOUISE BEO</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE LOUISE BEO</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>9-56-456</b>		17. INFORMANT <b>FRANCIS MATHEWS</b>	
17. ADDRESS <b>5913 HARPER'S FARM RD COLUMBIA MD 21044</b>		17. ADDRESS <b>5913 HARPER'S FARM RD COLUMBIA MD 21044</b>		17. ADDRESS <b>5913 HARPER'S FARM RD COLUMBIA MD 21044</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>AGEVD</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>E.P. Williamson II</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER <b>5350 BALTO NAT'L PK 21228</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>E.P. WILLIAMSON II</b>		ADDRESS <b>5350 BALTO NAT'L PK 21228</b>		DATE SIGNED <b>9/13/84</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-17-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARRISON Forest Mt. Cem</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>QUINCY Mills BALTO. MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>QUINCY Mills BALTO. MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>QUINCY Mills BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SLACK FUNERAL HOMES</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>SLACK FUNERAL HOMES</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>SLACK FUNERAL HOMES</b>	
25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1984</b>		25b. REGISTRAR'S SIGNATURE <b>W. Davidson-Pandell</b>		25b. REGISTRAR'S SIGNATURE <b>W. Davidson-Pandell</b>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPLAIN THE DELAY. **FOR THE FUNERAL DIRECTOR:** PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGES 4 AND 5 TO THE MEDICAL EXAMINER. **FOR YOUR FILES:** PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGES 4 AND 5 TO THE FUNERAL DIRECTOR. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. **WITHIN 72 HOURS** AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73



DHMH: 16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 4 2 3 6 9 6							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NICHOLAS THRASYBOULOS MATTHEWS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>September 15, 1984</b>		2b. HOUR <b>5:31 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 12, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>59</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mortician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Funeral Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1122 Green Acre Rd. 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thrasyboulos Matthews</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Demetra Carelas</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16b. SOCIAL SECURITY NO. <b>WW II 219-16-3346</b>		17. INFORMANT ADDRESS <b>Ann S. Matthews, 1122 Green Acre Rd. 21204</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> 19 <u>84</u> to <u>9-15</u> 19 <u>84</u> , that (II) (we) lost saw the deceased alive on <u>9-14</u> 19 <u>84</u> , and that in (III) (our) opinion death occurred on the date and hour and from the causes stated above, (IV) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Martin Magram</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <b>Sept. 16, 1984</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN MAGRAM MD</b>				22e. ADDRESS <b>7600 OXER DR SUITE 113 BALD. MD. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 19, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn, Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Matthews Funeral Home,</b>				24b. ADDRESS <b>21224 Eastern Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1984</b>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with this 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WALTER MILLER MC CARDELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 7, 1984</b>		2b. HOUR <b>2:02 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 20, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1147 F Charles View Way</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William McCardell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ann Browne</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-03-6965</b>		17. INFORMANT ADDRESS <b>Anne McCardell Same</b>			
18. CAUSE OF DEATH (Enter only PART I. DEATH WAS CAUSED IMMEDIATELY BY) <b>Abdominal Aortic aneurysm</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>with rupture as</b> (c) <b>final event</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerotic Heart Disease, COPD, Carcinoma of Colon and Prostate, Senile Dementia</b>							
19a. DATE OF OPERATION <b>Prostate</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Senile Dementia</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>December 80</b> to <b>Sept 7</b> 19 <b>84</b> , that (1) we last saw the deceased alive on <b>Sept 1</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Nelson Sun</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9 Sept 84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nelson Sun, M.D.</b>		22e. ADDRESS <b>Mercy Hospital, Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 10, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Gove</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>6500 York Rd.</b>		STATE REG. NO. BY REGISTRAR <b>SEP 10 1984</b>		25. REGISTRAR'S SIGNATURE <b>J. H. Davidson</b>	

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U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

January 1, 1911

Dear Sir:

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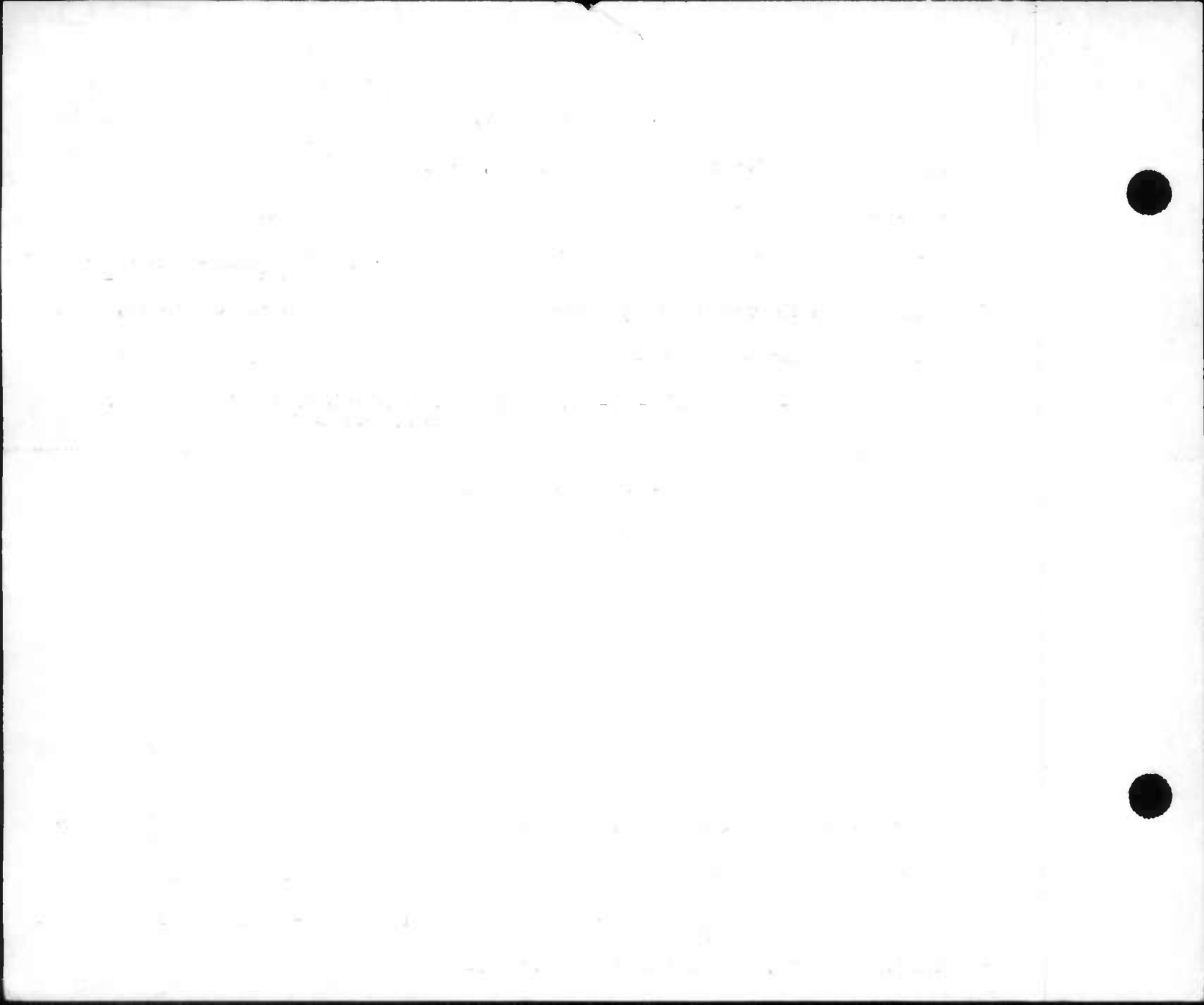
of the



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 23098

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
FRED D. McCauley, Sr.				09 05 '84		11:44A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		8. IF UNDER 1 YEAR	
Male		White		Dec. 25, 1902		81 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		USA				BALTIMORE COUNTY		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		GREATER BALTIMORE MEDICAL CENTER		Sales/Merchandising		Sinclair Oil Co		B-P	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		Cockeysville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		812D Cinnamon Ridge, 21030	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Ernst Radel McCauley		Grace Ford		No		216-05-2475		Fred D. McCauley, 104 Suffolk Rd. Savannah, Ga. 31410	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		RESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		INTRACEREBRAL HEMORRHAGE			
		(c)		DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/5 1984 to 9/5 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
DIANE PAPPAS		MD				9/5/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
DIANE PAPPAS, M.D.		GBMC - 6701 N. CHARLES ST. 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
Burial		9/7/84		Druid Ridge Cemetery		Pikesville		Balto. Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Martin D. Lawson, 10 W. Padonia Rd. 21093		SEP 6 1984		[Signature]					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

4 2 3 6 9 9

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET E. McCORD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9-21-84</b>		2b. HOUR <b>10:00 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 3, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stephen Wooden</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Loretta Walters</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-10-9876</b>		17. INFORMANT ADDRESS <b>Marie Bazemore same as 13 e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest.</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Hepatic failure</b> (c) <b>Hepatocarcinoma</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <b>9-17-84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Removal of liver mass</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William H. Maccenti</b>					22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William H. Maccenti MD</b>					22e. ADDRESS <b>7620 York Rd, Towson, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/25/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. 5305 Harford Rd. 21214</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 24 1984</b>		
			25b. REGISTRAR'S SIGNATURE <b>Carla Davidson-Randall</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

WILKINSON E. McCLEOD

Feb. 2, 1912

White

Female

Baltimore County

U.S.A.

Mr.

Tolson St. Joseph's Hospital

10th Corner St. 21224

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Baltimore

Mr.

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Woman

Stephen

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Baltimore, Maryland

St. Joseph's Hospital

Hotel

St. Joseph's Hospital, Inc. 1000 Madison St. Baltimore, Md.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23700

1 - FOR  
STATE  
REGISTRAR

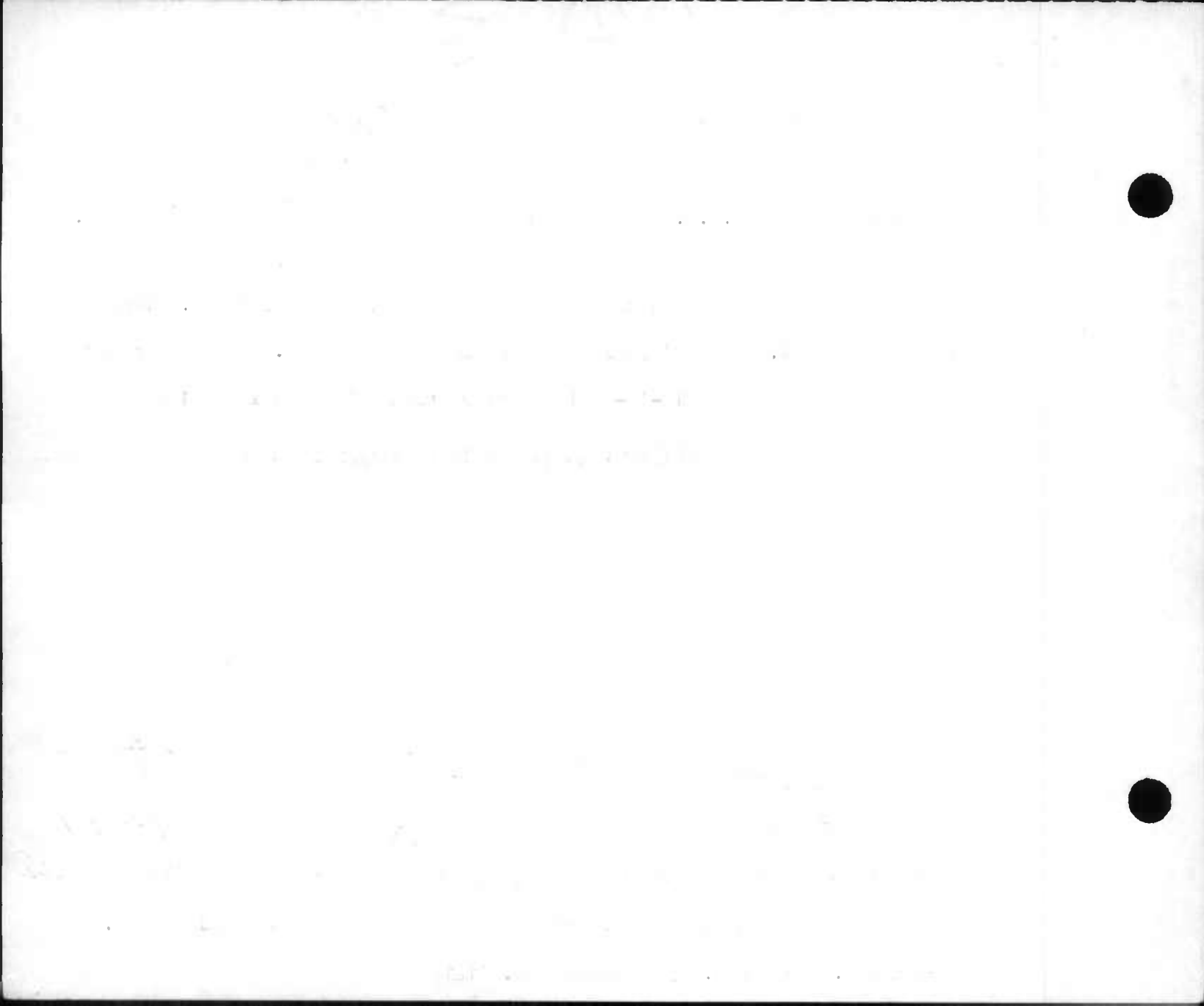
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY T. MIDDLE MC LAST LIPAW			2a. DATE OF DEATH MONTH DAY YEAR September 9-21-84			2b. HOUR 1:49 PM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 13 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Co. MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engraver		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY BALTIMORE		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1716 Wycliffe Rd. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Leo T. O'Sullivan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia A. Powers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-18-7271		17. INFORMANT ADDRESS Helen Wright 1716 Wycliffe 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c).								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from July 19 82, to Sept 21 19 84, that I saw the deceased alive on Sept 20 19 84, and that in my opinion death occurred on the date and hour and from the causes stated above. (did) (did not) view the body after death.										
22b. SIGNATURE Lawrence Boas M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/21/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Boas M.D.			22e. ADDRESS 54 SCOTT ADAM RD COCKEYSVILLE MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/26/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Towson, Baltimore Md.			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Rd. 21214					25a. DATE REC'D. BY REGISTRAR SEP 24 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

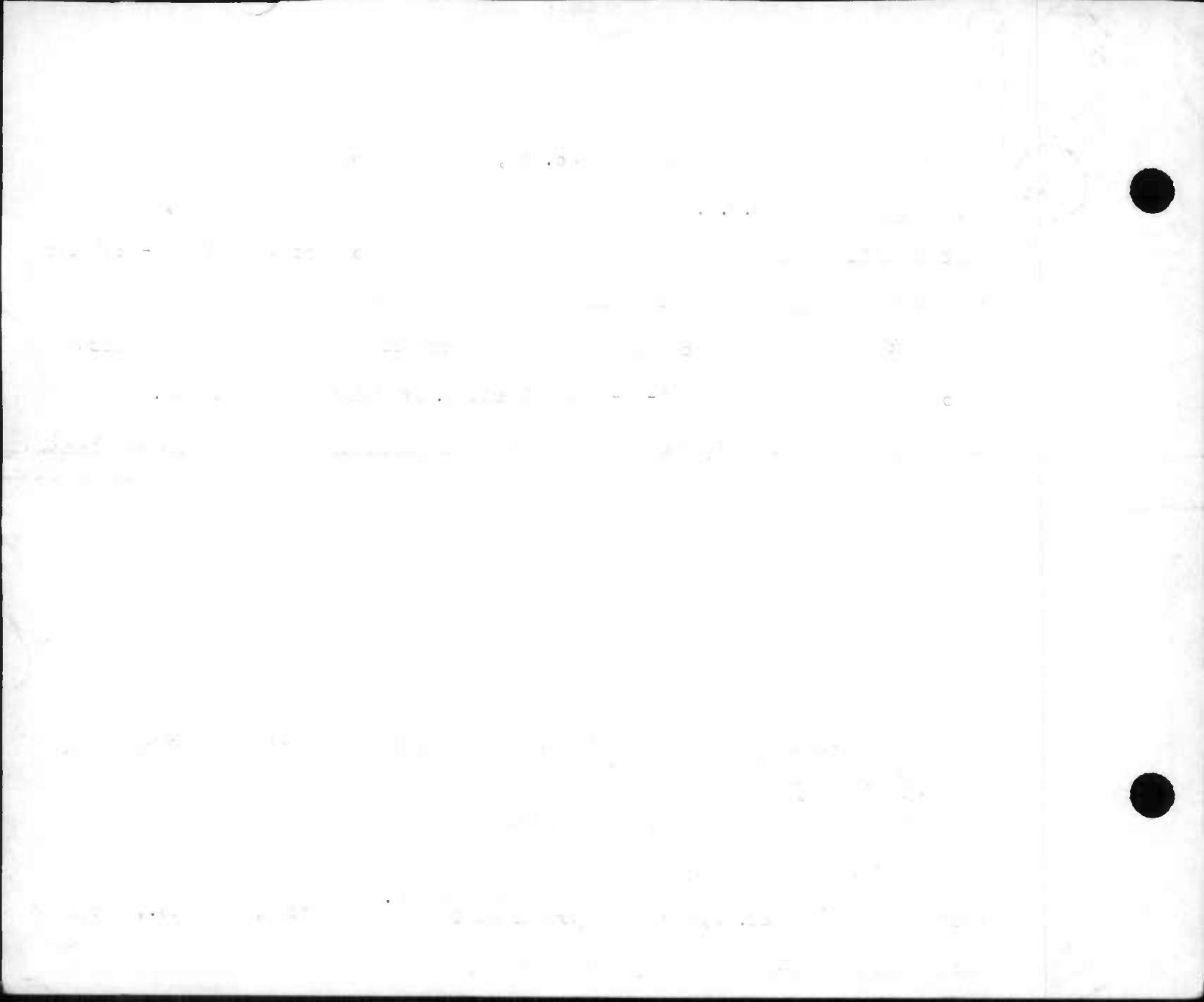
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REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN</b> <b>McGUIGAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 28, 1984</b>		2b. HOUR M <b>AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 18, 1899</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>	7. UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ireland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Lutherville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10 Haddington Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Combustion Engineer-Expditor</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Lutherville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>10 Haddington Road 21093</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alex</b> <b>Mc</b> <b>Guigan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriett</b> <b>Anderson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>062-09-7081</b>	17. INFORMANT ADDRESS <b>Marie F. Mc Guigan Same as #13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7-14</b> <b>19</b> <b>74</b> <b>84</b> P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7600 Osler Drive</b> <b>Butter, Balto., Maryland</b>			
22a. I certify that (1) (the deceased) attended the deceased from <b>8-27-84</b> to <b>9-28-84</b> , that (1) (he) lost saw the deceased alive on <b>8-27-84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above) (I) (we) did (did not) view the body after death					22c. DATE SIGNED <b>9/28/84</b>
22b. SIGNATURE <b>Frank G. Kuehn</b>		DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frank G. Kuehn, M.D.</b>		22e. ADDRESS <b>7600 Osler Drive</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Oct. 1, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gunpowder Meeting</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Butter, Balto., Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 2 1984</b>			
ADDRESS <b>1050 York Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

BP \_\_\_\_\_





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 23702

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPH C. Mc INNIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 30, 1984</b>		2b. HOUR <b>4:10P M</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 29, 1934</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US of A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PLANT HELPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CHEVRON U.S.A.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH BETHEA</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ALEAN Mc INNIS</b>		13e. STREET ADDRESS / ZIP CODE <b>5709 STONINGTON AVE. 21207</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>251 50 6037</b>		17. INFORMANT ADDRESS <b>MRS. NAOMI C. Mc INNIS 5709 STONINGTON AVE.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>probably</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>9/26</b> 19 <b>84</b> , to <b>9/30</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/26</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>F. Kawaja</b> THE PHYSICIAN'S NAME (TYPE OR PRINT) <b>TAHOORA KAWAJA</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10-1-84</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/5/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PARK</b>	
24. FUNERAL DIRECTOR NAME <b>LEWIS T. GWYNN</b>		ADDRESS <b>4517 PARK HEIGHTS AVENUE</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT. 1, 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	
				23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE (BALTO.) MD.</b>	

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BALTIMORE COUNTY GENERAL HOSPITAL

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MRS. MARY C. MC LANE 2509 STOCKTON AVE.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosa Elizabeth McJilton			2a. DATE OF DEATH MONTH DAY YEAR Sept. 15, 1984		2b. HOUR 1:00 PM	
3 SEX Female	4 RACE White	5. DATE OF BIRTH Oct. 14 1886	6. AGE (IN YEARS LAST BIRTHDAY) 97	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balt			
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Garden Village Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13. STREET ADDRESS 1 Britt Court 21221
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14. FATHER'S NAME FIRST MIDDLE LAST Henry Ruppert	15. MOTHER'S MAIDEN NAME LAST Margaret Weismunder
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 46 1270	17. INFORMANT ADDRESS Ruth E. Hinkle, Daughter 1 Britt Ct. Apt 201 Balto., Md. 21221
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>		years
DUE TO, OR AS A CONSEQUENCE OF (c) —		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Recent Pneumonia + Congestive Heart Failure, Recent Urinary Tract Infection</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

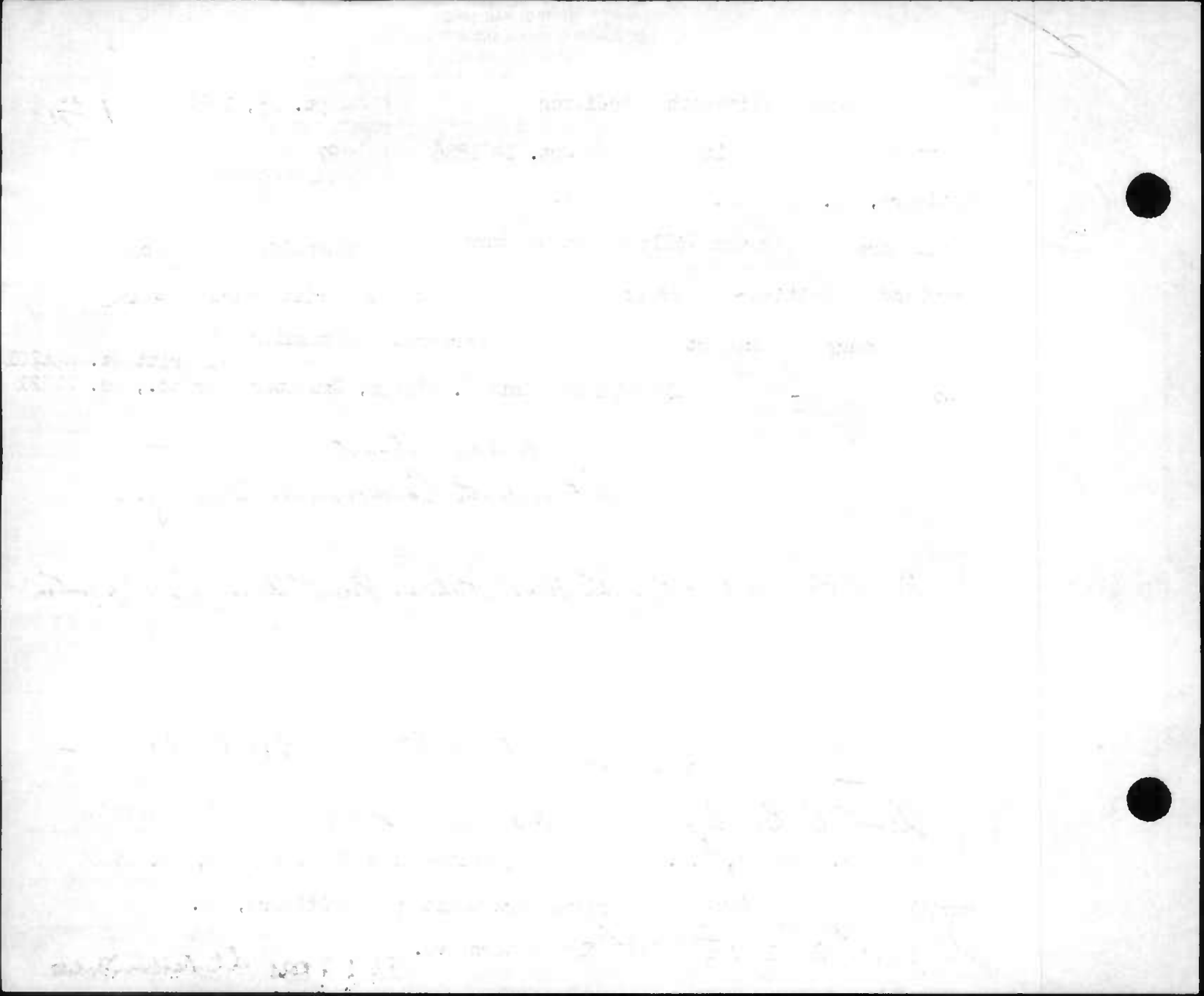
22a. I certify that (I) (the physician) attended the deceased from 8/17/84 to 9/15/84, that (I) (we) last saw the deceased alive on 9/11/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE <u>Albert B. Bradley</u>	DEGREE MD	22c. DATE SIGNED 9/17/84
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT B. BRADLEY, M.D.	22e. ADDRESS 4900 BELAIR ROAD BALTIMORE, MD. 21206
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23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 9/17/84	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION Baltimore, Md. COUNTY STATE
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24. FUNERAL HOME <u>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.</u>	25a. DATE REC'D. BY REGISTRAR SEP 19 1984	25b. REGISTRAR'S SIGNATURE <u>Lidia Davidson-Randall</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified within 24 hours.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SARAH JANE McKinney			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 8, 1984		2b. HOUR 2:51 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 3 1934	6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Line		12b. INDUSTRY Continental Manufacturing
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Wills		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Rugemer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-30-2005	17. INFORMANT ADDRESS James E. McKinney Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLI BILATERAL</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ILIAC VEIN THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GANGRENOUS NECROSIS OF LEGS, S/P CORONARY</u> ARTERY BYPASS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a					
19a. DATE OF OPERATION ,		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>SEPTEMBER 6</u> , 19 <u>84</u> , to <u>SEPTEMBER 8</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>SEPTEMBER 8</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (do) view the body after death.					
22b. SIGNATURE <i>Risa Davis</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RISA DAVIS M.D.		22e. ADDRESS 9000 FRANKLIN SQUARE DRIVE 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/12/1984	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 10 1984 <i>John H. Ruck</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23705

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DOROTHEA N. MCLEAN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>9/17/84</b>		2b HOUR <b>9:00P M</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 10, 1914</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b CITIZEN OF WHAT COUNTRY? <b>Balto.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10 CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N CHARLES ST GBMC</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>MD</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>9 Aigburth Road, 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Nahatzki</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte Weidner</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	16b SOCIAL SECURITY NO. <b>213 10 6632</b>	17 INFORMANT ADDRESS <b>William H. McLean, Same</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC BREAST CANCER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that <del>he</del> (this hospital) attended the deceased from <b>9/10</b> , 19 <b>84</b> , to <b>9/17</b> , 19 <b>84</b> . <del>He</del> (we) last saw the deceased alive on <b>9/17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Jay M. Lustbader</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/17/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. J.M. LUSTBADER</b>		22e ADDRESS <b>GBMC</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>9/20/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., MD</b>		
24 FUNERAL DIRECTOR NAME ADDRESS <b>Henry W. Jenkins &amp; Sons Co. 4905 York Road Balto., MD 21212</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 20 1984</b>	25b. REGISTRAR'S SIGNATURE <i>Frederick Randall</i>	

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Henry V. Jenkins, Jr. Co.

• For more information, call 1-800-368-5868



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BROADUS BURCH MCMANUS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 11 '84</b>		2b. HOUR <b>12:15A</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6/8/1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTO. MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPERVISOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Grocery</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>ESSEX</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES BURCH MCMANUS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY E. GLASS</b>		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			17b. SOCIAL SECURITY NO. <b>237.09.4141</b>		17. INFORMANT ADDRESS <b>RUTH L. MCMANUS (WIFE) (SAME AS 13e)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8-19</b> , 19 <b>84</b> , to <b>9-11</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9-11</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>D Pappas MD</i>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/11/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D Pappas MD</b>				22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>9/12/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>
24. FUNERAL DIRECTOR NAME <b>WALTER BROOKS BRADLEY INC., BALTO., MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1984</b>		
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

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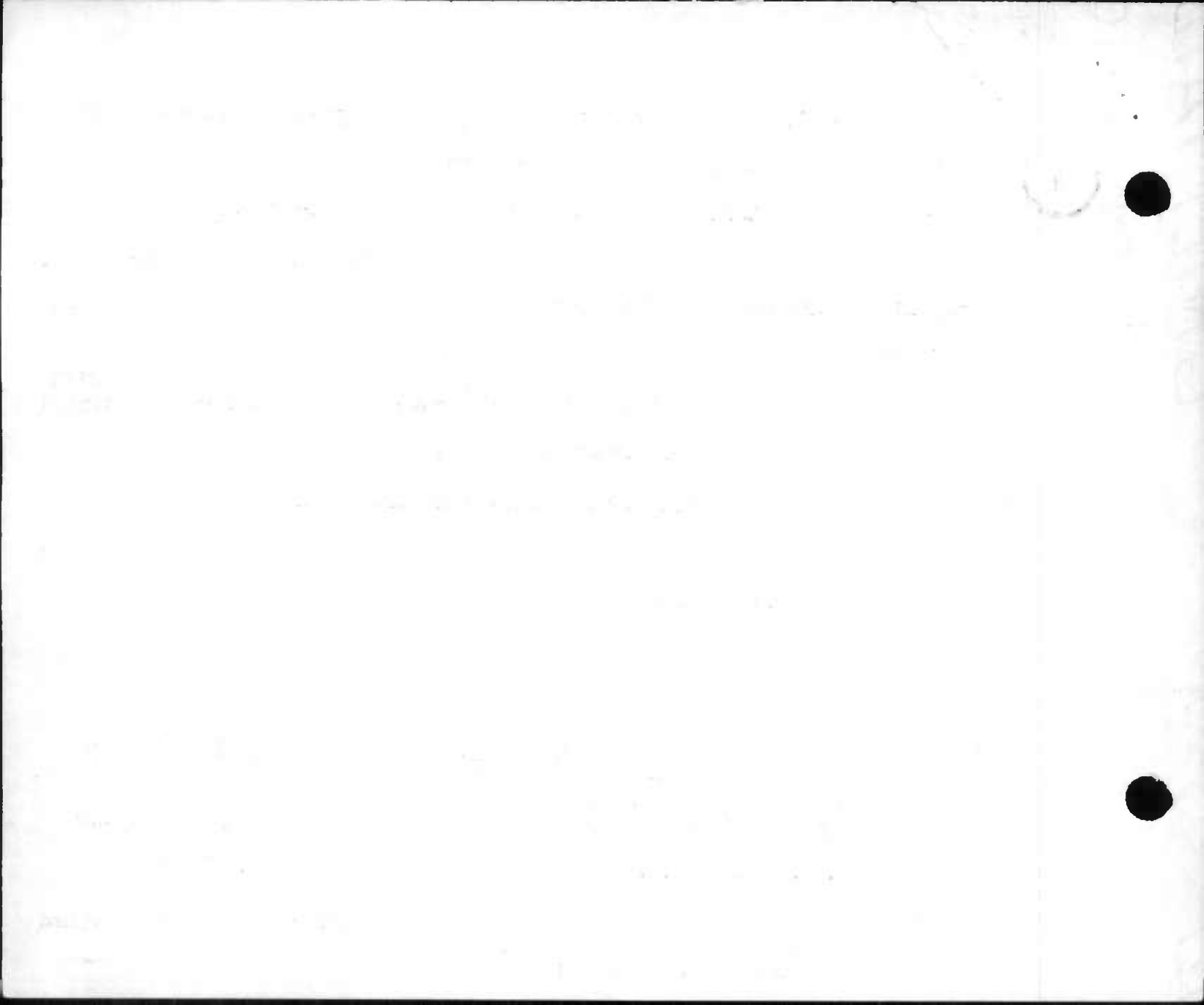
11-6-64

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23707

1. DECEASED NAME (TYPE OR PRINT) <b>Mrs. Ida Irene Meekins</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 19 1984</b>			2b. HOUR <b>2:50a</b> M				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 13 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD				
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Bus</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Driver Balto.Co</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Middleborough</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>313 Wye Road 21221</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Burns</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Burns</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-14-8746</b>	
16c. ADDRESS <b>313 Wye Road Baltimore Maryland</b>			17. INDIAN NAME			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Hypertension</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <b>September 19 1984</b> to <b>September 19 1984</b> , that (we) last saw the deceased alive on <b>September 19 1984</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (not) view the body after death.)										
22b. SIGNATURE <b>J. A. Sumner MD</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>9-19-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. A. Sumner, M.D.</b>			22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>09-22-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Carroll Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		
24. ADDRESS <b>8728 Liberty Road Randallstown, Maryland 21133</b>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

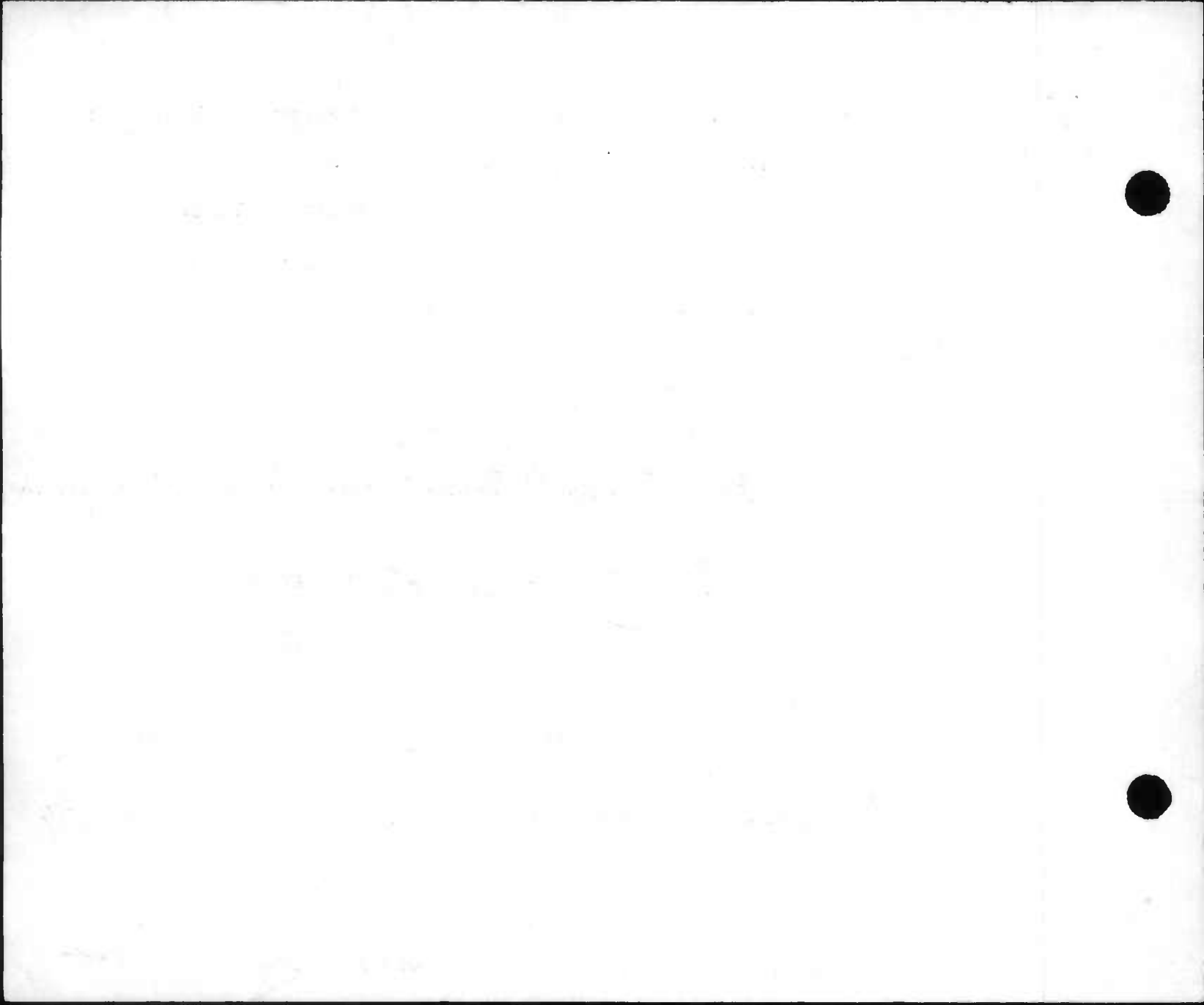
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie M. Meister			2a. DATE OF DEATH MONTH DAY YEAR September 10, 1984		2b. HOUR 2:00p M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 23, 1898		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS MONTHS DAYS		
10. CITY OR TOWN OF DEATH ROSSDALE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STRESS BAER CO.		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 3215 WILLOWHAY ROAD 21234		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN PARKVILLE		
14. FATHER'S NAME FIRST MIDDLE LAST John GOSB		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna KNOERLEIN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 214 01 2796		17. INFORMANT ADDRESS Family Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy DUE TO OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Cardiovascular Dis DUE TO OR AS A CONSEQUENCE OF (c) Diabetes - Mild late onset		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OF PART 1 OR PART 2)		21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)		
22a. I certify that (I) (this hospital) attended the deceased from 9/6/84 to 9/13/84, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If not, view the body after death.)						
22b. SIGNATURE OF PHYSICIAN Frank T. Kasik, Jr. MD		DEGREE MD		22c. DATE SIGNED 9/13/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK T. KASIK, JR.		22e. ADDRESS 9005 HARFORD ROAD - PARKVILLE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-14-1984		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPL OF MEMORIES 8800 HARFORD ROAD		25a. DATE REC'D. BY REGISTRAR SEP 24 1984		
25b. REGISTRAR'S SIGNATURE John Davidson						

BP



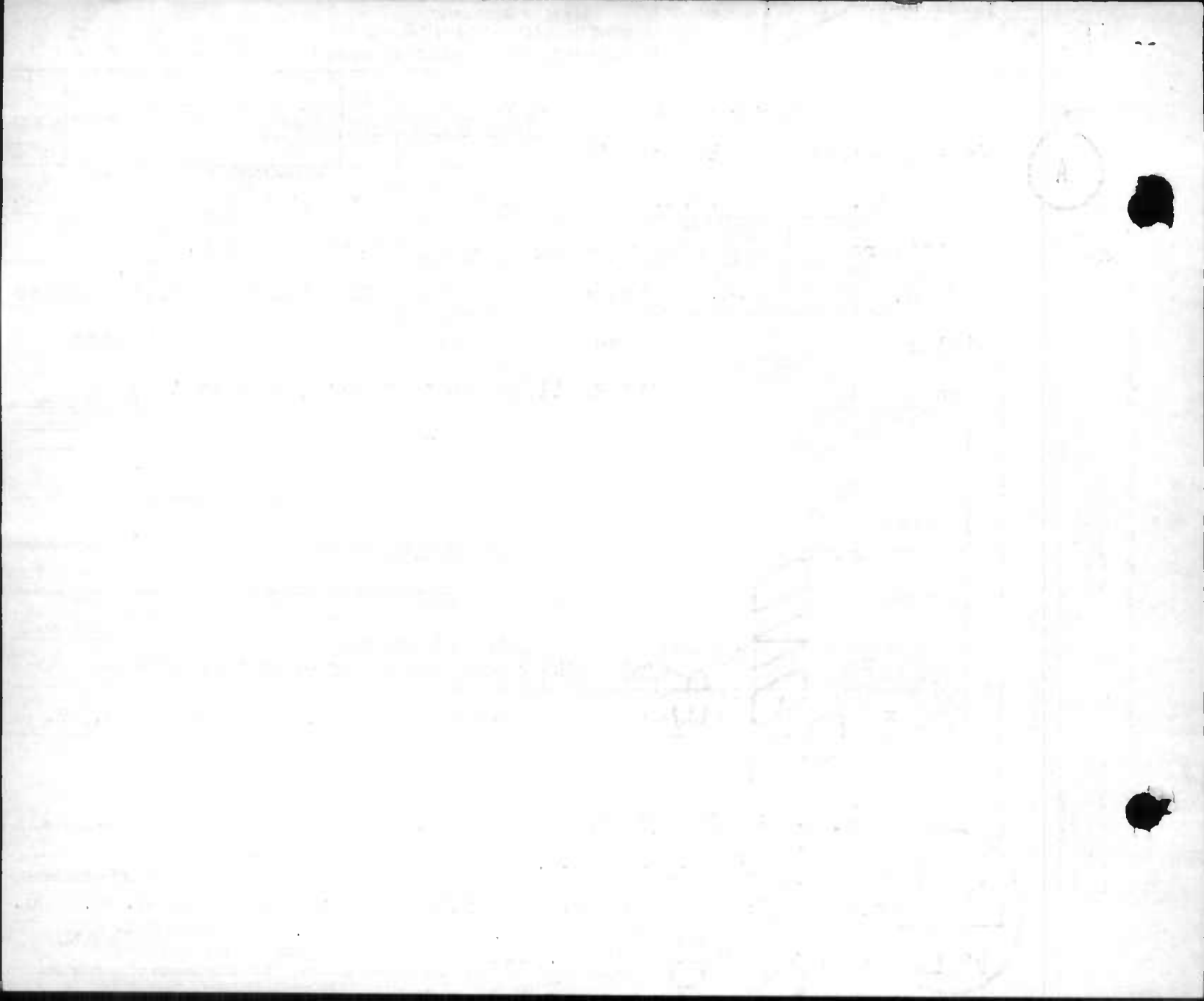
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 OR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 18-22a 12/10/84 mtd #4590

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23709

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
ELIZABETH L. MELTON		9-26-84		12:55 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
female	white	6 MONTH 20 DAY 28 YRS	56	MONTHS	DAYS
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED	
Md.		U.S.A.		NEVER MARRIED	
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		14. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		Greater Baltimore Medical Center		Baltimore County	
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		A.A.		Jessup	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS	
William		Mae		20794	
17. WAS DECEASED EVER IN U.S. ARMED FORCES?		18. SOCIAL SECURITY NO.		19. INFORMANT	
no		212 26 1167		Frank Melton (same as 13E)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Lacerations of vena cava</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> .					
(b) <u>during removal of right lobe of liver</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR		during removal of right lobe of liver	
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		Hospital		Greater Balto. Med. Center Baltimore, Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
<u>Margarita A. Korell</u>		M.D. Assistant MEDICAL EXAMINER		9-27-84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Margarita A. Korell, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
burial		9/29/84		Gardens of Faith	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George J. Gonce		OCT 3 1984		<u>Julia Davidson</u>	
26. NAME		27. ADDRESS		28. CITY OR TOWN	
4001 Ritchie Hwy.		Baltimore Md. 21225		Overlea Balto. Co. Md.	





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be first of all

20  
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23710

1. DECEASED NAME (TYPE OR PRINT) <b>Mr. Raymond Gerard Merkle</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 17 1984</b>				2b. HOUR <b>7:45 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 1 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>	
7a. BIRTHPLACE (COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Monument Dealer</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Merrymount</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8343 Merryview drive 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Merkle</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Metcalf Merkle</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-32-4055</b>		17. MARRIAGE ADDRESS <b>Mrs. Marilyn J. Irwin 21784</b>				17. ADDRESS <b>5509 Strawbridge Terrace Sykesville Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARDIAC ARRHYTHMIA -</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-13</b> 19 <b>84</b> , to <b>9-17</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9-17</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. R. Depestre</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/17/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R - DEPESTRE</b>				22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSP</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/20/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

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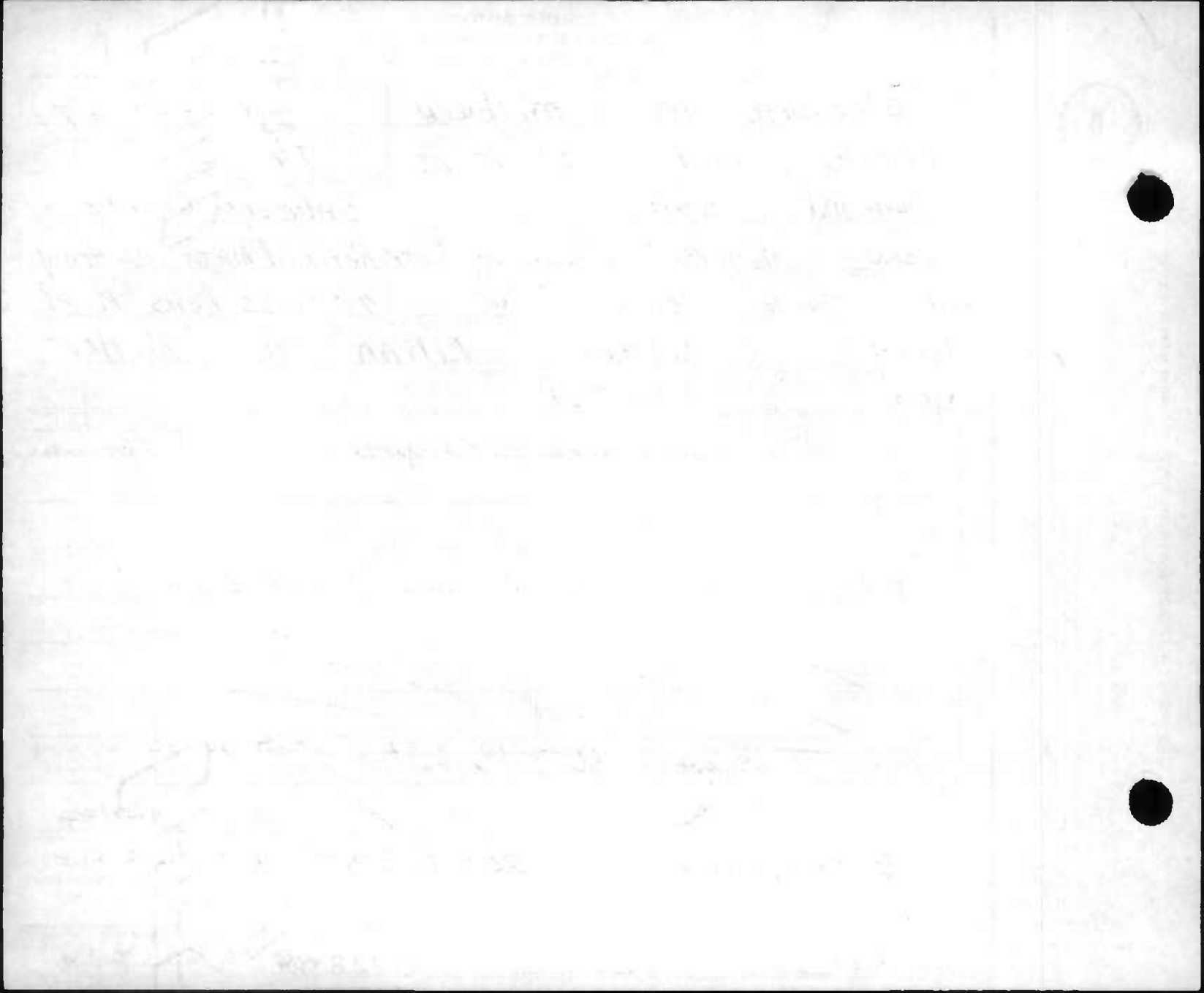
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth M Milburn</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>20</b> YEAR <b>84</b>		2b. HOUR <b>4:00</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>03</b> DAY <b>15</b> YEAR <b>08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto, Md</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Multi Medical Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Major</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>13a. STATE <b>Md</b></b>			13b. COUNTY <b>Balto.</b>		
13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>7-3 Cross Keys Road. 21215</b>		
14. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b>MAHool</b> LAST <b>MAHool</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Lilian</b> MIDDLE <b>H.</b> LAST <b>Blatter</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>219-16-2964</b>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary embolism</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Alzheimer's disease, lymphoma of left leg.</b>					
19a. DATE OF OPERATION <b>May 10, 1982</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>lymphoma of left leg</b>		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1982</b> to <b>Sept 20, 1984</b> , that (I) (we) lost saw the deceased alive on <b>Sept 15, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E Beritock</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/20/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E BERITOCK</b>		22e. ADDRESS <b>302 E 33rd St Balto 21218.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b. DATE <b>9-20-84</b>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>State Anatomy Board</b> ADDRESS <b>Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lillian Anderson-Randall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be completed by the medical examiner.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

6 4 2 3 7 1 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alphonse R. MILITO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 7, 1984</b>		2b. HOUR <b>3:15P<sup>M</sup></b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 7 1911</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Colorado</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Barber</b>			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Rosedale</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Milito</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Fratzello</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>193-09-5249</b>		17. INFORMANT ADDRESS <b>Jean A. Rudacille Same as 13e</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <b>Liver Failure, Cirrhosis, Alcoholism</b>	
	DUE TO, OR AS A CONSEQUENCE OF (c) _____	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that ☒ (this hospital) attended the deceased from August 26, 19 84, to September 7, 19 84, that ☒ (we) lost  
saw the deceased alive on September 7, 19 84, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated  
above ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Carlos J. Page</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/7/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARLOS J. PAGE</b>		M.D.		22e. ADDRESS <b>9000 Franklin Square Dr INTERNAL MED. FRANKLIN SQUARE HOSP.</b>		21237	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/10/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>				25a. DATE REC'D. BY REGISTRAR (2nd REGISTRAR) <b>SEP 10 1984</b>			



Handwritten scribble or signature.



THE WINE MERCHANTS' ASSOCIATION OF THE UNITED STATES OF AMERICA  
INCORPORATED  
1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Andrew J. MILLER			2a. DATE OF DEATH MONTH DAY YEAR September 26, 1984			2b. HOUR 9:10AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR June 12, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rossdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Crown, C + Seal		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN PARKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew T. Miller					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary S. Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. II		17. INFORMANT FAMILY RECORDS		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal bleeding producing Hypotension, secondary to heart failure and Hypovolemia, with contributing Respiratory failure, Malnutrition, renal failure, wound Dehiscence with small bowel fistula. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Recent myocardial infarction, perforated peptic ulcer with extensive peritonitis and sepsis, Diabetes Mellitus.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from September 1, 19 84, to September 26, 19 84, that (X) (we) lost saw the deceased alive on September 26, 19 84, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature] DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/26/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ben Jagiello, MD						22e. ADDRESS 9000 Franklin Square Dr., 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-29-1984		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE ROSSDALE BALTO. MARYLAND			
24. FUNERAL DIRECTOR NAME EVANS CHAPSL OF MEMORIALS						25a. DATE REC'D. BY REGISTRAR SEP 28 1984		25b. REGISTRAR'S SIGNATURE June Davidson-Rendall		

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*[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

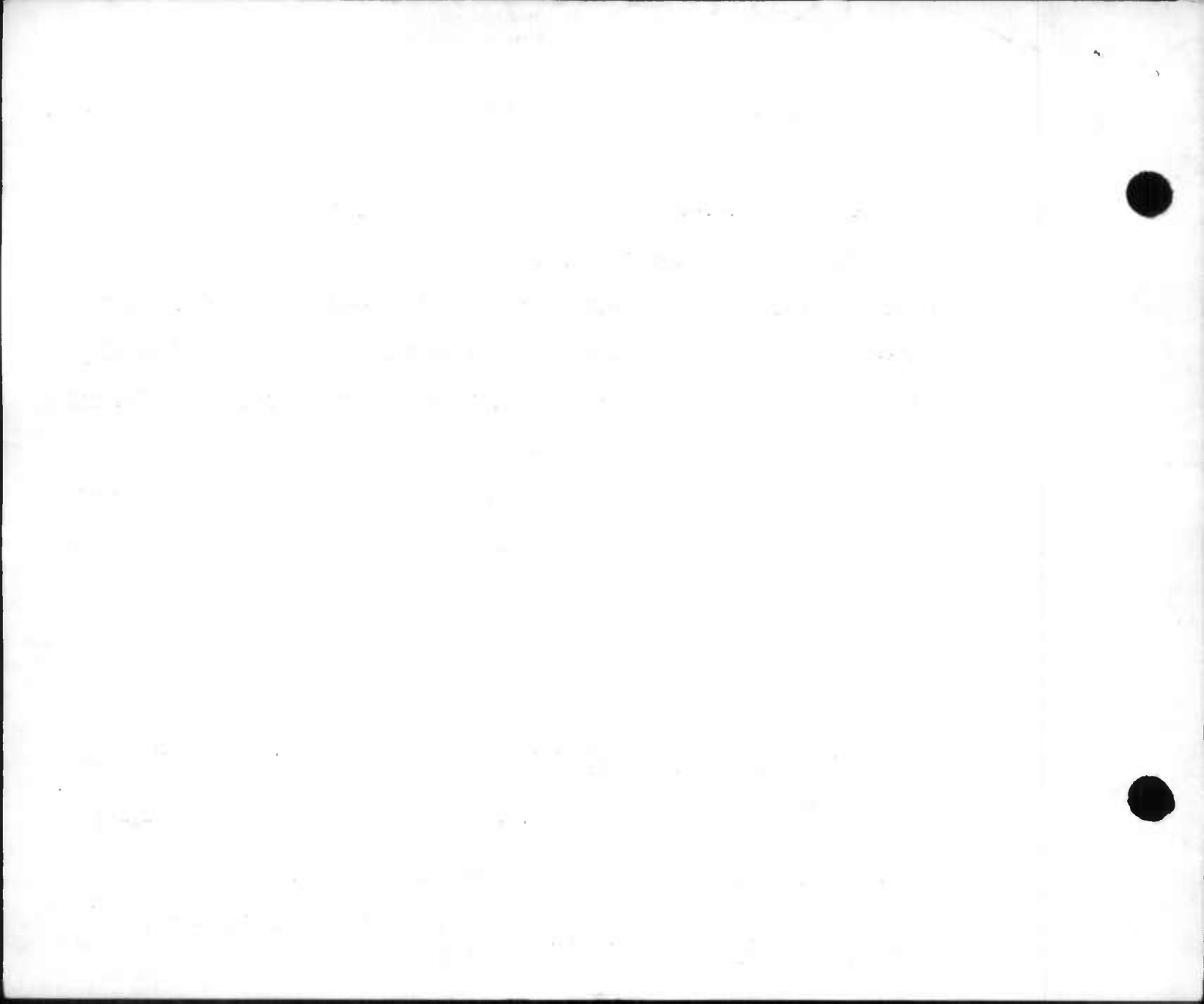
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 23714

REG. NO.

1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST BARBARA MILLER		2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 3, 1984		2b. HOUR 6 A.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 6, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3503 ORCHARD AVE. 21207		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3503 ORCHARD AVE. 21207	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH GREELEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERONICA UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. 213-16-6841		17. INFORMANT ADDRESS MR. ROBERT MILLER 3503 ORCHARD AVE. 21207							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>acute cerebro-vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>Jan 12, 1961</u> to <u>Sept. 3, 1984</u> that (1) (we) last saw the deceased alive on <u>August 2, 1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not see the body after death.									
22b. SIGNATURE <i>[Signature]</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-4-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MORTON ELLIN		22e. ADDRESS 5310 OLD COURT RD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/4/84		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CEM		23d. LOCATION CITY OR TOWN COUNTY REISTERSTOWN BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215		25a. DATE REC'D. BY REGISTRAR SEP 7 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 2 3 / 1 5	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
LEROY B. MILLER				9/26/84		10:58PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Nov. 11, 1903		80		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				BALTIMORE COUNTY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON		6701 N CHARLES ST GBMC		Farmer		Own Farm					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore		Monkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17150 Big Falls Rd./21111			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
John Best Miller		Alverta Miller									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
no		218-26-1331		Robert Miller, Parkton, MD		2738 Mt. Carmel Rd. 21120					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) RESPIRATORY ARREST											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) INTRACEREBRAL HEMORRHAGE											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/26, 19 84, to 9/26, 19 84, that (I) (we) lost saw the deceased alive on 9/26, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
DR. D. PAPPAS						MD		9/27/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
						GBMC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		Sept 29, 1984		Hereford Baptist Cem.		Parkton, Balto., MD					
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
J. J. Hartenstein, New Freedom, PA 17349		OCT 4 1984		J. J. Hartenstein							

YTHUC 39017A

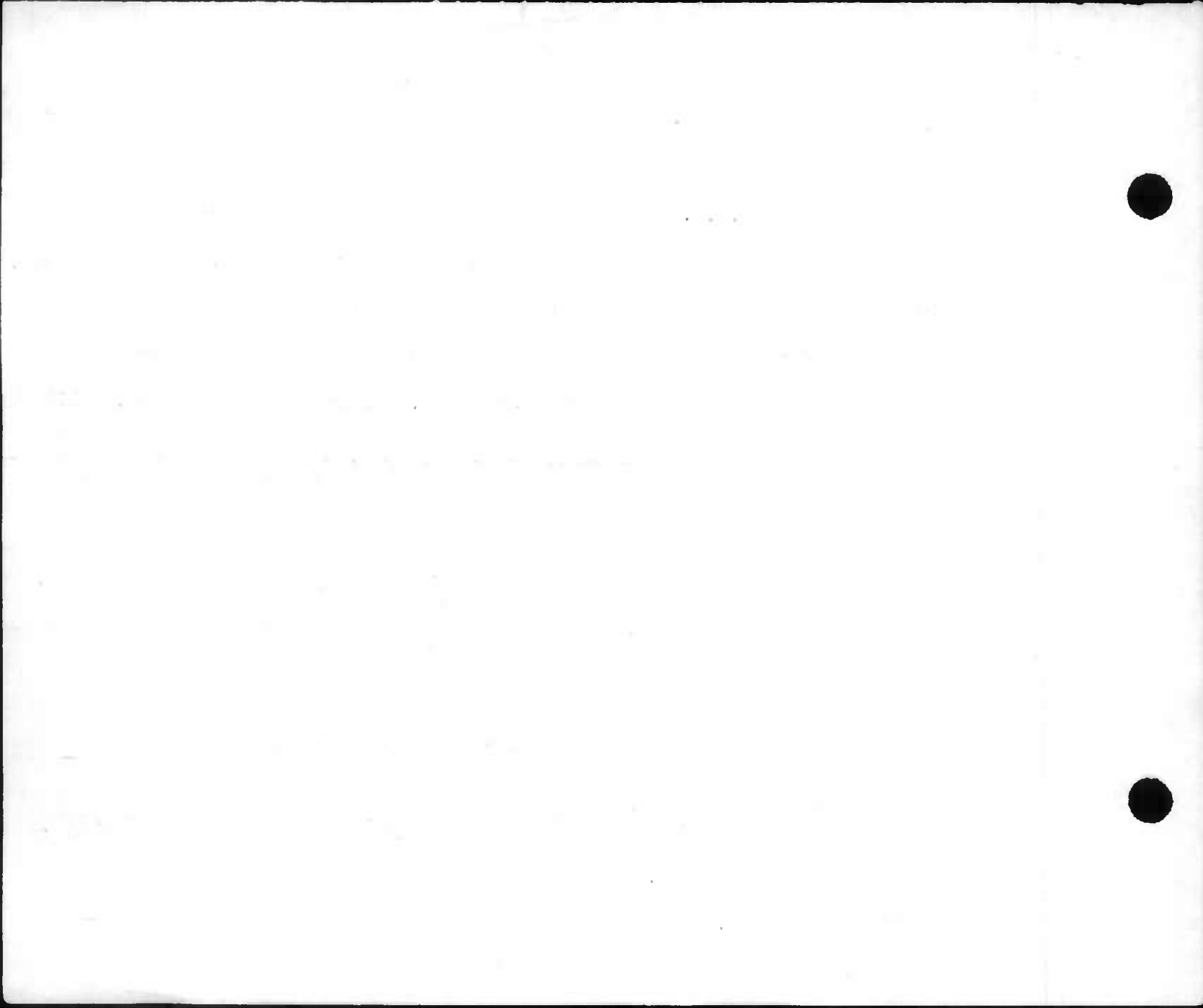
**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 4 2 3 / 1 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARIAN M. MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 3 84</b>		2b. HOUR <b>4:20 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 8 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>29 Tanglewood Road 21228</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Personnel Dir.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Hutzlers Dept. Store</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Catonsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>29 Tanglewood Road 21228</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis Marion Merchant</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Ross</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-01-1063</b>		17. INFORMANT ADDRESS <b>Willard L. Miller 29 Tanglewood Rd. 21228</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of urinary bladder</b> DUE TO, OR AS A CONSEQUENCE OF <b>Removal of Bladder</b> Conditions, if any, <b>Bladder papillary serous cyst adenocarcinoma</b> gave rise to immediate cause (a), stating the underlying cause last <b>of unknown cause</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1983</b> <b>1962</b> <b>1975</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>All tumors were primary lesions</b>					
19a. DATE OF OPERATION <b>8/16/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Tumor urinary bladder with bleeding</b>		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER FACTORY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)	
21a. INJURY OCCURRED AT HOME <input type="checkbox"/> IN SCHOOL <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>8/13/84</b>		21c. LOCATION (CITY OR TOWN) COUNTY STATE <b>9/3/84</b>	
22a. I certify that (1) (this hospital) attended the deceased from <b>8/13/84</b> to <b>9/3/84</b> that (1) <input type="checkbox"/> last seen the deceased alive on <b>8/13/84</b> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (2) <input type="checkbox"/> view the body after death.					
22b. SIGNATURE <b>W E McGrath MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/4/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Edward McGrath, MD.</b>		22e. ADDRESS <b>1303 Frederick Road</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9/7/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 5 1984</b>	25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

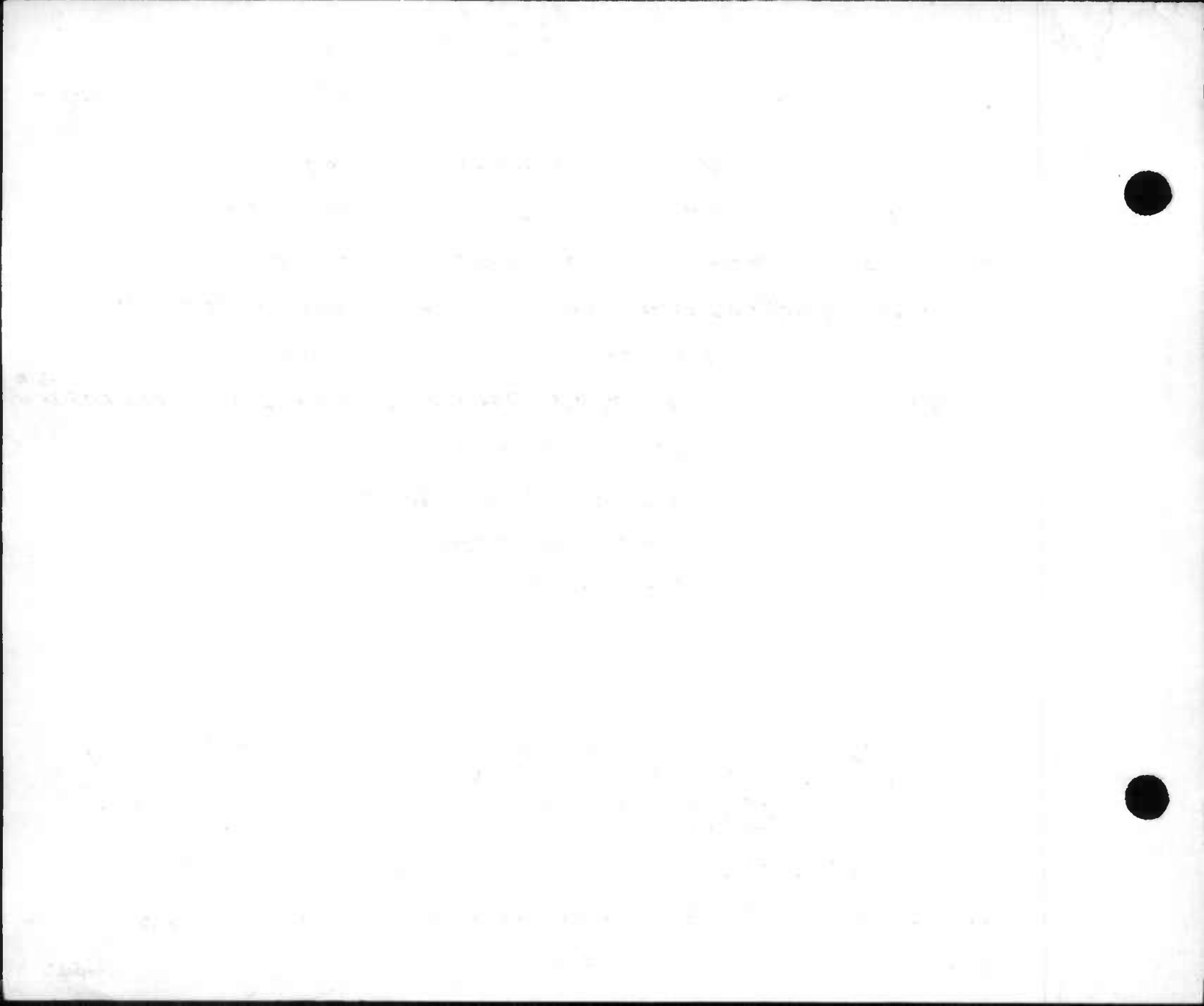
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia R. MILLER			2a. DATE OF DEATH MONTH DAY YEAR September 20, 1984		2b. HOUR MIN. 2:10 P M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1/29/20		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN EDGEWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE 1211 CHAPPER DR 21040		14. FATHER'S NAME FIRST MIDDLE LAST DOCKERY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VANK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 227 24 7030		17. INFORMANT ADDRESS DARRYL MATAROTLA 725 EASTERN AVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma Of The Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Leukopenia, Sepsis, Acute Pulmonary Edema</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from <u>September 20, 1984</u> to <u>September 20, 1984</u> that (we) last saw the deceased alive on <u>September 20, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.						
22b. SIGNATURE S. El Amir		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/20/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sherif El Amir, MD		22e. ADDRESS 9000 Franklin Square Drive, 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL - BURIAL		23b. DATE 9/21/84		23c. NAME OF CEMETERY OR CREMATORY LAUREL GROVE CEM		23d. LOCATION CITY OR TOWN COUNTY STATE NORTON VA
24. FUNERAL DIRECTOR NAME J.G. CONNELLY		ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR SEP 26 1984		25b. REGISTRAR'S SIGNATURE L. Anderson-Rodell

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 336-5736.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 4 2 3 7 1 8

1- FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST William J MILLER SR.		MONTH DAY YEAR September 30, 1984	
2b. HOUR		12:05A <sub>M</sub>	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
M	W	MONTH DAY YEAR 3/22/98	86
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
MD.		USA	
7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		Baltimore County, MD.	
ROSSVILLE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY	
FRANKLIN SQ.		POLICE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	
13b. STATE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD.		13e. STREET ADDRESS	
13c. COUNTY		21220	
BALTO.		1336 GOOSENECK RD.	
13d. CITY OR TOWN		15. MOTHER'S MAIDEN NAME	
MIDDLE RIVER		UNK	
14. FATHER'S NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
UNK		YES	
16b. SOCIAL SECURITY NO.		17. INFORMANT	
220 05 9348		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) Cardiac Arrest			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			
(b) Inferior Myocardial Infarction			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
Severe Chronic Obstructive Pulmonary Disease			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from September 21, 1984, to September 30, 1984, that (X) (we) last saw the deceased alive on September 30, 1984, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I/We) (did) (did not) view the body after death.		22c. DATE SIGNED	
22b. SIGNATURE		DEGREE	
K. Mason, MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Karen Mason, M.D.		9000 Franklin Square Drive 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		10/3/84	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
GARDENS OF FAITH		BALTO. MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME ADDRESS J.G. CONNELLY 300 MALE		OCT 3 1984	
25b. REGISTRAR'S SIGNATURE			
Twidson-Randall			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

4 2 3 7 1 9

1. DECEASED NAME (TYPE OR PRINT) <b>THELMA E. MITTEN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 12, 84</b>		2b. HOUR <b>3 A M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 27 1902</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co., Gen'l Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hwf</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Reisterstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>298 Butler Road 21136</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Swartzbaugh</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Myrtle Owings</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>	
16b. SOCIAL SECURITY NO. <b>214-30-7083</b>		17. INFORMANT ADDRESS <b>Mrs. Joan Stonesifer, Reisterstown Md. 21136</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic hypertension cardio-</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 22, 1984</b> to <b>Sept. 12, 1984</b> , that (I) (we) lost saw the deceased alive on <b>Sept. 12, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Sharon Pountabbed</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9-12-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHASSEM Pountabbed</b>		22e. ADDRESS <b>Balto. Co. General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-14-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Mem. Gard.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Finksburg Carroll Md.</b>
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home, Reisterstown, Md.</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1984</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23720

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LUCY (LISETTA) MORGANTI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 29, 1984</b>		2b. HOUR <b>2:40 A.M.</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10-8-1907</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PIETRO STIRPE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NUNCIATA</b>		13e. STREET ADDRESS / ZIP CODE <b>7922 HIGHPOINT RD. 21234</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>119-03-2629</b>	17. INFORMANT ADDRESS <b>Mr. Henry Jirini - 7922 Highpoint Rd. 21234</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>uncertain, poss. pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Fracture, right hip, plus below</b> <b>8/3/84</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Intestinal Atony, Diabetes Mellitus C.O.H.D., Coronary art Dis</b>					
19a. DATE OF OPERATION <b>8/6/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Austin-Moore Prosthesis - r hip</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7626 York Rd TOWSON MD 21204</b>	
22a. I certify that (this hospital) attended the deceased from <b>8/23/84</b> to <b>9/29/84</b> , that (we) least saw the deceased alive on <b>9/29/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death.					
22b. SIGNATURE <b>Lester A. Wall Jr</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/29/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LESTER A. WALL JR</b>		22e. ADDRESS <b>7626 York Rd TOWSON MD 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>10-2-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY MOUNT CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>TUCKAHOE, NEW YORK</b>	
24. FUNERAL DIRECTOR NAME <b>Barthel Miller</b>		ADDRESS <b>- 7527 Hayford Rd. BALTO MD</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	



XC 15740642

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 7 2 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELDREN DENNIS MORRIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 16, 1984</b>		2b. HOUR <b>11:25 P M</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 20, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>V.A. MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>DUNDALK</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>8309 KAVANAUGH ROAD 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDGAR MORRIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GUERNEY CHRISTINE SHIFLETT</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II 227 18 6236</b>		17. INFORMANT ADDRESS <b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 HOURS</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>RIGHT MIDDLE LOBE PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE OF DEATH (ENTER IN THIS SPACE) <b>PONTINE HEMORRHAGE, RECURRENT PNEUMONIA, RECURRENT URINARY TRACT INFECTION, STATUS POST PNEUMING GASTROSTOMY.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) received the deceased from <b>SEPTEMBER 6 1984</b> to <b>SEPTEMBER 16 1984</b> , that (we) last saw the deceased on <b>SEPTEMBER 16 1984</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE <b>P V Kanani</b>		DEGREE <b>M D</b>		22c. DATE SIGNED <b>9/17/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PRADIP KANANI, M.D.</b>		22e. ADDRESS <b>V.A.M.C., FORT HOWARD, MARYLAND 21052</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>9/18/1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>
24. FUNERAL DIRECTOR <b>WALTER BROOKS BRADLEY INC., BALTO., MD. 21222</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1984</b>		
			25b. REGISTRAR'S SIGNATURE <i>Walter Brooks Bradley</i>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DAVID B Mossen</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>4</b> YEAR <b>84</b> 2b. HOUR <b>10<sup>30</sup> A.M.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>6</b> YEAR <b>1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>College</b>
13a. STATE <b>Md.</b>	13b. COUNTY <b>Cockeysville</b>	13c. CITY OR TOWN <b>Cockeysville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>10325-J Malcolm Circle 21030</b>
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Mosser</b> LAST <b>Mosser</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Katherine</b> MIDDLE <b>Black</b> LAST <b>Black</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-10-2767</b>		17. INFORMANT <b>Mr. Robert Mosser</b> ADDRESS <b>902 Starbit Road Towson, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction acute</b> <b>Terminal</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chromome, lung</b> <b>34 case</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerosis generalized</b>				
19a. DATE OF OPERATION <b>—</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (we) (hospital) attended the deceased from <b>Jan. 68</b> to <b>Sep 4 84</b> , that (I) (we) (hospital) saw the deceased alive on <b>9-4-</b> 19 <b>84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Wm Carl Ebeling MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-4-84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm CARL EBELING MD</b>		22e. ADDRESS <b>7401 Olsen Dr Balto Md 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>	23b. DATE <b>9/4/84</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SFP 7 1984</b>
		25b. REGISTRAR'S SIGNATURE <b>P. Davidson-Randall</b>		

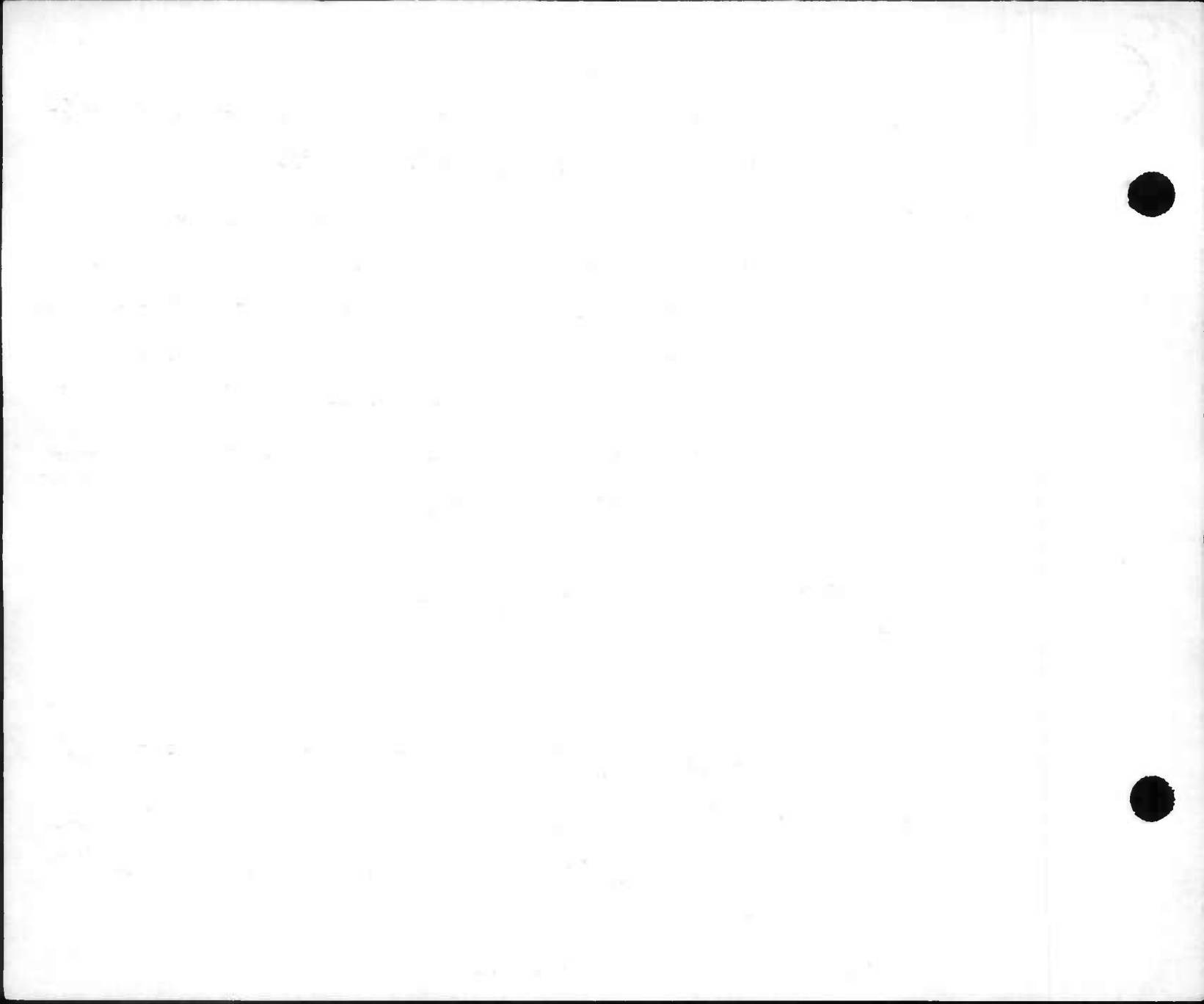
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23723			
1. DECEASED NAME (TYPE OR PRINT) <b>MARY S. MROZIEWSKI</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>09/05/84</b>			
3. SEX <b>Female</b>				2b. HOUR <b>6:40 AM</b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 24 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Poland</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Forest Haven Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sepchanski</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marianna</b>		16. STREET ADDRESS <b>7534 Central Way 21122</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215 74 4467</b>		17. INFORMANT <b>Daughter</b> ADDRESS <b>Poland Spring, Me.</b>			
17. INFORMANT <b>Sophia Radziszewski</b>		18. SOCIAL SECURITY NO. <b>RFD #1 Box 4170</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe arteriosclerosis cerebri</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>vascular disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12</b> , 19 <b>76</b> , to <b>9-5</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>8-2</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Harold Bobb MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-6-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold Bobb</b>		22e. ADDRESS <b>7220 Park Heights 21208</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9 8 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George Gonce</b>		24b. ADDRESS <b>4001 Ritchie Hwy Balto Md</b>		25a. DATE RECD. BY REGISTRAR <b>SEP 10 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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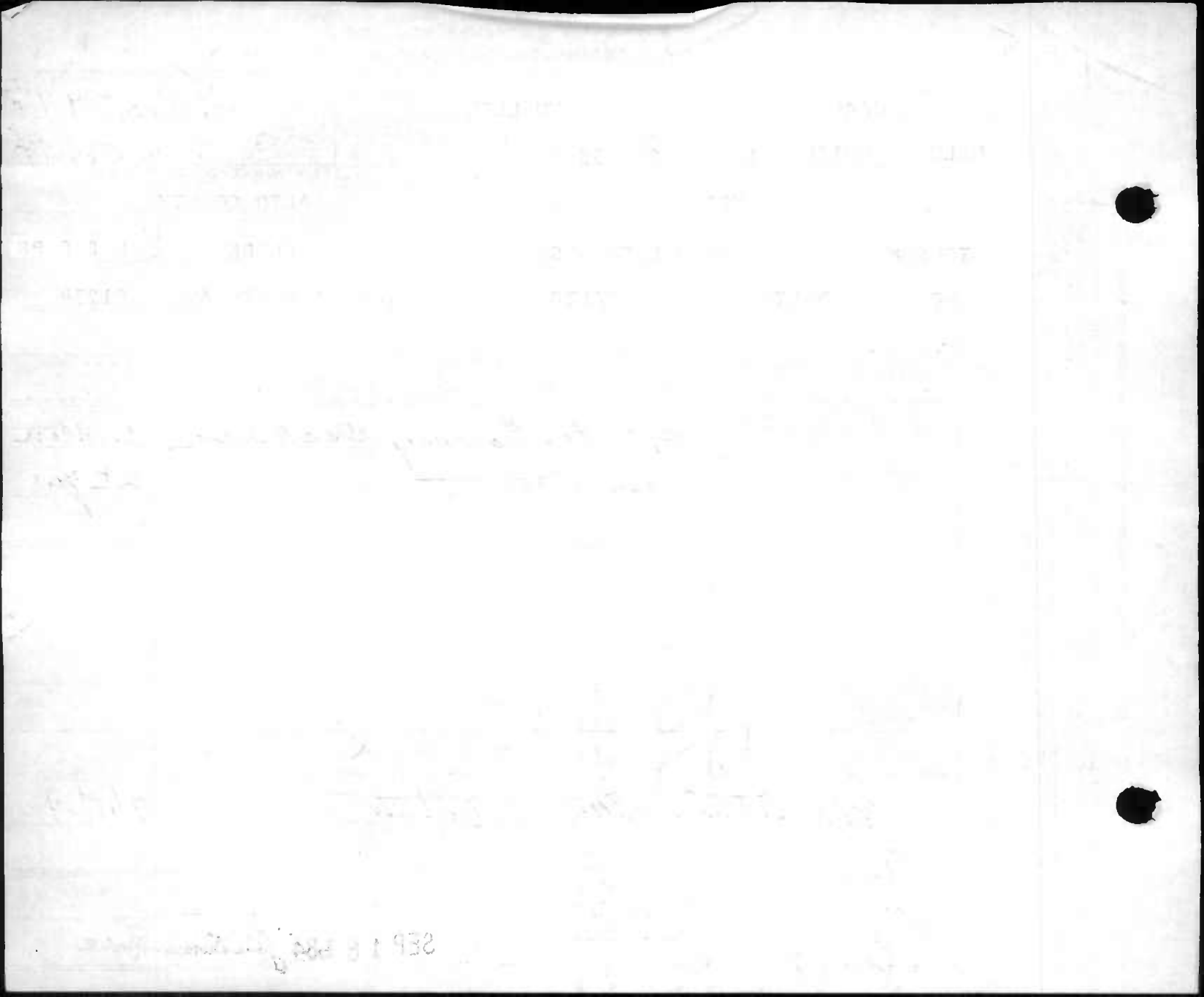


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>JACK O MUELLER</b>						2a. DATE KNOWN OF DEATH ESTD. <b>September 15 1984</b> 9:15 PM			
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>06</b> YEAR <b>28</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>55</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	7c. DATE PRONOUNCED DEAD <b>September 15 1984</b> 9:15 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPH HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Chessie Sys Railroad</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2811 FIFTH AVE 21234</b>	
14. FATHER'S NAME FIRST <b>Otto W.</b> MIDDLE <b>Mueller</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>Della</b> MIDDLE <b>Hart</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>213-28-6458</b>		17. INFORMANT ADDRESS <b>Thelma Hurley Box 462 Neavitt, Md. 21652</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>ASCD</b> (b) <b>ASCD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCD</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2+ yrs</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>Charles O. [Signature]</b>				TITLE (SPECIFY) <b>Deputy</b>		M.D. <b>Deputy</b>		DATE SIGNED <b>9/15/84</b>	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-19-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louden Park Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Balto., Md.</b> COUNTY STATE		
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			
9705 Belair Road, Balto., Md. 21236									



SEP 18 1932

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, NEARLY EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M 2/80

56 FILM 6595  
9/17/84 Km

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23125

FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
Nellie Elizabeth Mumma

2a. DATE KNOWN OF DEATH MONTH DAY YEAR  
September 10 1984

2b. HOUR  
11:45 PM

3. SEX Female

4. RACE Caucasian

5. DATE OF BIRTH (IN YEARS) MONTH DAY LAST BIRTHDAY  
April 24 1926 58

IF UNDER 1 YR. MONTHS DAYS HOURS MIN.

6. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Georgia

7b. CITIZEN OF WHAT COUNTRY?  
U. S. A.

9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore County MD.

10. CITY OR TOWN OF DEATH  
Cockeysville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
10004 Apt. M Hill Green Circle

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE  
Maryland

13b. COUNTY  
Baltimore

13c. CITY OR TOWN  
Cockeysville

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒

13e. STREET ADDRESS  
10004 Apt. M. Hill Green Circle

13f. ZIP CODE  
21030

14. FATHER'S NAME FIRST MIDDLE LAST  
Samuel Ashton Barton

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Irene Widener

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
No

16b. SOCIAL SECURITY NO.  
254-30-3035

17. INFORMANT  
Constance Mumma Shultz  
10004 Apt. M Hill Green Circle 21030

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary Artery Disease  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
(b) Generalized Atherosclerosis  
DUE TO, OR AS A CONSEQUENCE OF  
(c)  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
5+ yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  
Multiple Sclerosis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?  
YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Charles F. O'Donnald M.D. TITLE SPECIALIST

EXAMINER'S NAME Charles F. O'Donnald ADDRESS 7501 York Road

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
BURIAL

23b. DATE  
09/13/84

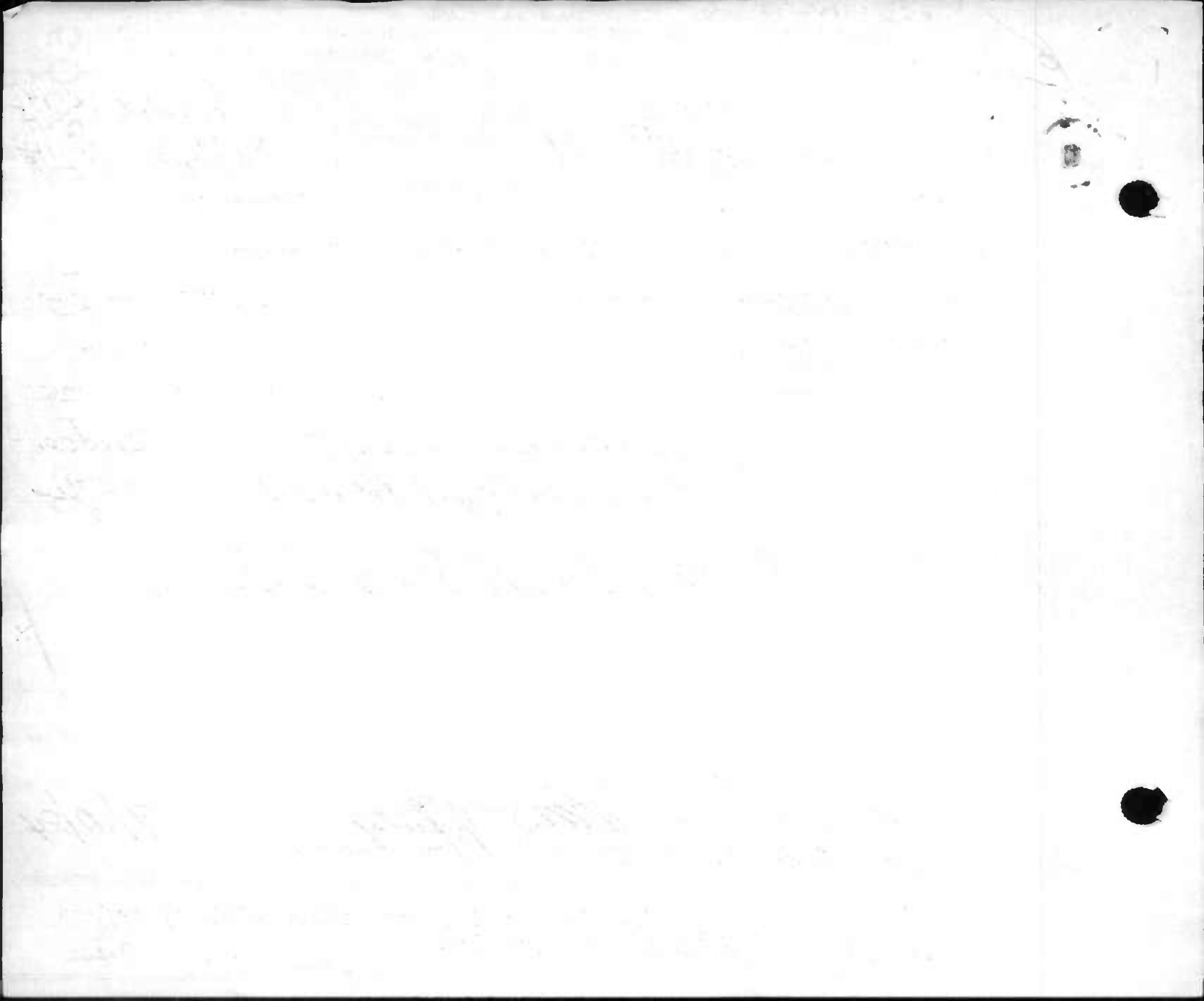
23c. NAME OF CEMETERY OR CREMATORY  
Lorraine Park Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE  
Woodlawn Baltimore Maryland

24. FUNERAL DIRECTOR NAME  
Loring Byers, Funeral Directors, Inc.

25a. DATE REC'D. BY REGISTRAR  
SEP 11 1984

25b. REGISTRAR'S SIGNATURE  
Julia Davidson-Randall





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

#6, FilmG596 10/10/84 KAM				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23720			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES Luther Mummert</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9 26 84</b>				2b. HOUR <b>2:25 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 25 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE RUXTON</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tool and Die Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tool &amp; Die</b>					
13a. STATE <b>Md</b>		13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>604 Gladstone Avenue 21210</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Henry Mummert</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Minerva Wisner</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218 12 0925</b>		17. INFORMANT <b>Edith Mummert same</b>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <b>6/19</b> , 19 <b>84</b> , to <b>9/26</b> , 19 <b>84</b> , that (we) last saw the deceased alive on <b>9/26/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>John W. Bowe MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9/26/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/29/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville, Balto. Co. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Burgee-Henss Funeral Home,</b>				ADDRESS <b>21211 3631 Falls Road</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lia Davidson-Randall</b>			

BP \_\_\_\_\_

1

10/1/50

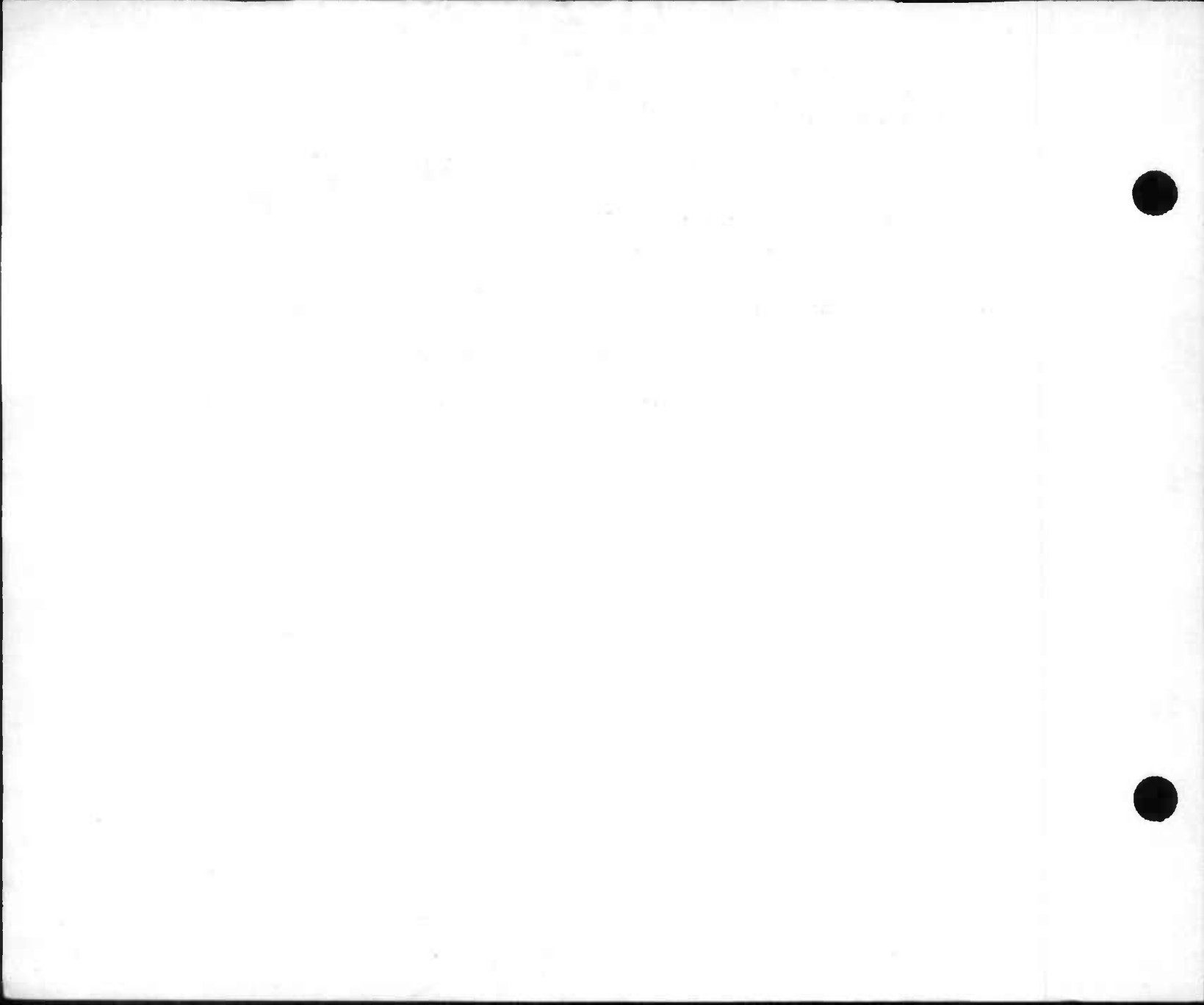
10/1/50

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR DORIS M. MURPHY

1. DECEASED NAME (TYPE OR PRINT) <i>Doris M. Murphy</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>09-11-84</i>			2b. HOUR <i>11 AM</i>			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12-19-23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>60</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore General Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Woodlawn</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1935 Winder Road 21207</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>David Metzbower</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Alice Hamilton</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>WW 2 219-18-4930</i>		17. INFORMANT <i>John J. Murphy</i>		ADDRESS <i>Same as # 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIORESPIRATORY ARREST</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable Myocardial Infarction</i>								<i>Sudden</i>	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>May</i> 19 <i>83</i> to <i>Present</i> 19 <i>84</i> , that (we) lost saw the deceased alive on <i>9/11</i> 19 <i>84</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Herman Brecher M.D.</i>						DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>7/11/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Herman Brecher, M.D.</i>						22e. ADDRESS <i>6410 Windsor Mill Rd 21207</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>9/14/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Catonsville Md.</i>			
24. FUNERAL DIRECTOR <i>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</i> <i>1630 Edmondson Avenue, Catonsville, Md. 21228</i>						25a. DATE REC'D. BY REGISTRAR <i>SEP 13 1984</i>			
25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

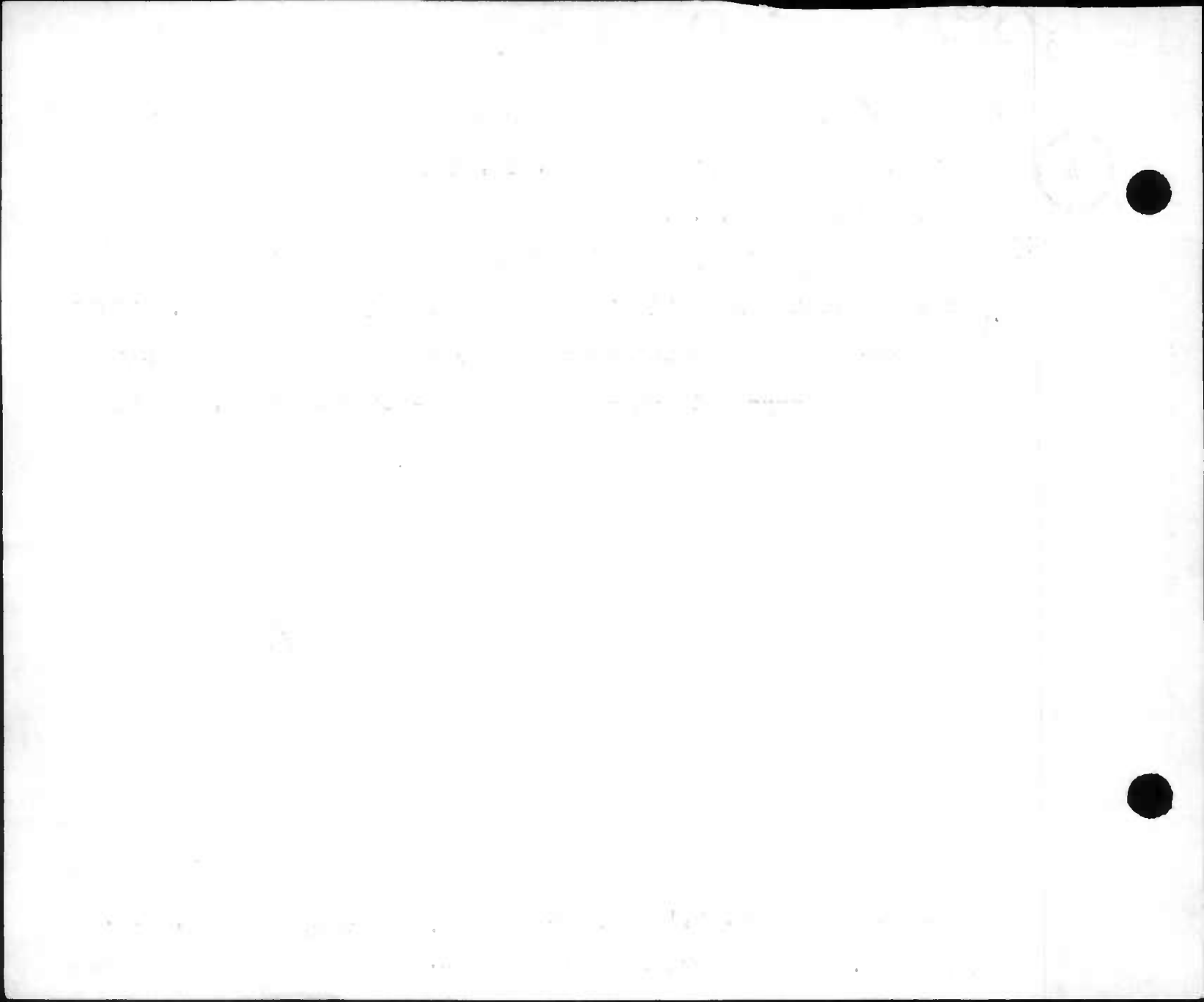
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUBY C MURPHY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT 28 1984</b>		2b. HOUR <b>9:30 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 17, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>21093</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Hurchinson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Walton</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>157-18-0046</b>		17. INFORMANT ADDRESS <b>Jack Taggart Hampstead, MD 21074</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT LEFT HEMISPHERE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>BILATERAL INTERNAL CAROTID COLLISIVE DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK A) WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/4</b> , 19 <b>84</b> , to <b>9/28</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>9/28</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Lope T. Villa Jr.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9/29/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LOPE T. VILLA JR.</b>		22e. ADDRESS <b>7600 OSLER DRIVE, TOWSON, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SEE COPY) <b>Burial</b>		23b. DATE <b>Oct. 2, '84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Absecon Presby. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Absecon, N.J.</b>
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>		ADDRESS <b>8521 Loch Raven Blvd.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>Gelia Davidson-Randall</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Owen Myrick			2a. DATE OF DEATH MONTH DAY YEAR 9 30 84			2b. HOUR 12:40 M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 10 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1718 Bayard Ave.				12a. USUAL OCCUPATION (WORKING LIFE) Maintenance Engineer		12b. KIND OF BUSINESS OR INDUSTRY Nat. Brewery	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1718 Bayard Ave 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas H. Myrick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Stienmetz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-6831		17. INFORMANT ADDRESS Elsie C. Myrick same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA-UNKNOWN primary</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 MONTHS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10 Sept</u> , 19 <u>84</u> , to <u>16 Sept</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>16 Sept</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard S. Kaplan</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard S. KAPLAN MD				22e. ADDRESS UMCC 22 S. GREENE ST. Baltimore 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/3/84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				25a. DATE REC'D. BY REGISTRAR OCT 4 1984		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 3 7 3 0

1. DECEASED NAME (TYPE OR PRINT) George Henry NITZEL			2a. DATE OF DEATH MONTH DAY YEAR September 20, 1984		2b. HOUR 6:10 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 31 05		
6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
11. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Nitzel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Not Known		16. STREET ADDRESS / ZIP CODE 204 N. Marlyn Ave. 21221		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17b. SOCIAL SECURITY NO. 213-10-8084		17. INFORMANT Mildred L. Nitzel same as 13c		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Lower Lobe Pneumonia, Possible Urinary</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease, Permanent Pace Maker Inserted</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Chronic Renal Failure, Diabetes Mellitus</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 19, 19 84</u> , to <u>September 20, 19 84</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>September 20, 19 84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.						
22b. SIGNATURE <u>N Okum, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>9/20/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Okum, M.D.		22e. ADDRESS 9000 Franklin Square Dr., 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-22-84		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.		
23d. LOCATION CITY OR TOWN Westview		COUNTY Md.		STATE		
24. FUNERAL DIRECTOR NAME Duda-Ruck, inc.		ADDRESS 7922 Wise Ave. Baltimore, Md. 21222		25a. DATE REC'D. BY REGISTRAR SEP 26 1984		
25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>						

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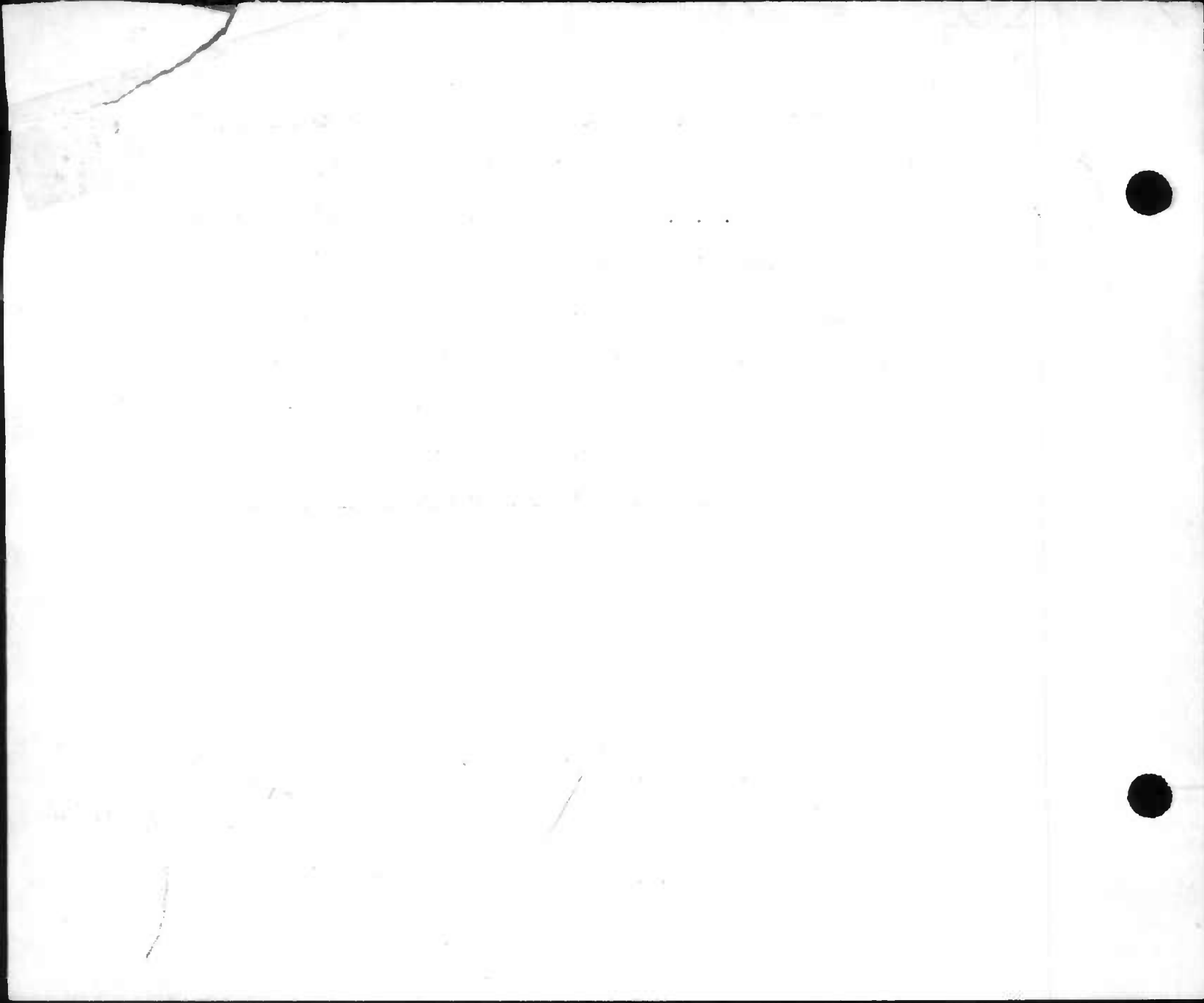
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Joseph C. NOLAN</b>						2a DATE OF DEATH MONTH DAY YEAR <b>September 18, 1984</b>		2b HOUR <b>6:45P M</b>	
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1 27 43</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. <b>41</b>		IF UNDER 1 YEAR IF UNDER 7-14 HRS. MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Essex</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE COUNTY <b>Maryland</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>818 N. Belnord Avenue 21205</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph A. Nolan</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gladys V. Chew</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO. <b>214-40-2128</b>		17 INFORMANT ADDRESS <b>Helen Nolan 818 N. Belnord Avenue</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Carcinoma of pancreas with liver metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>September 10, 1984</b> to <b>September 18, 1984</b> that (I) (we) last saw the deceased alive on <b>September 18, 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>9/18/84</b>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. Barrynechea, M.D.</b>				22e ADDRESS <b>9000 Franklin Square Drive - 21237</b>					
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>BURIAL</b>		23b DATE <b>9/24/84</b>		23c NAME OF CEMETERY OR CREMATORY <b>King MEMorial Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown, Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b>				24b ADDRESS <b>1101 E North Avenue</b>		25 DATE REC'D BY REGISTRAR (SM REGISTRATION SIGNATURE) <b>SEP 19 1984</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Iris B. Noppenberger			2a. DATE OF DEATH MONTH DAY YEAR 9 15 84		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 17 32		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 183 Stanmore Rd. 21212		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Balto.	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 183 Stanmore Rd. 21212
14. FATHER'S NAME FIRST MIDDLE LAST Otis Hynson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtian Saunders			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 219-28-4423		17. INFORMANT ADDRESS Paul Noppenberger 183 Stanmore Rd. 21212	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Squamous Cell Carcinoma of Tongue</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>84</u> , to <u>Sept 15</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Aug</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE <u>Davis M Hahn</u>		DEGREE M.D.		27c. DATE SIGNED 9/15/84	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Davis M. Hahn M.D.		27e. ADDRESS 5601 Loch Raven 21239 Professional Office Building Suite 107			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/17/84	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld		ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR SEP 18 1984	25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		6 4		2 3 7 3 3	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3. SEX		4. RACE	
ELLA LOLITA NUETZEL		SEPTEMBER 1, 1984		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Dec. 1, 1902		81		Maryland		U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
		Baltimore County, MD.		Towson		St. Joseph Hospital	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12c. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE	
Maryland		Machine Operator		Clothing		8735 Lackawanna Rd. 21234	
13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Robert		Sallie	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS	
No		214-03-0900		George M. Nuetzel		21234 Lackawanna Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:		PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) SEPSIS		IMMEDIATE CAUSE (a) SEPSIS		IMMEDIATE CAUSE (a) SEPSIS		IMMEDIATE CAUSE (a) SEPSIS	
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA		DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA		DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA		DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA	
DUE TO, OR AS A CONSEQUENCE OF (c) PREDNISONE THERAPY AND BREAST CANCER		DUE TO, OR AS A CONSEQUENCE OF (c) PREDNISONE THERAPY AND BREAST CANCER		DUE TO, OR AS A CONSEQUENCE OF (c) PREDNISONE THERAPY AND BREAST CANCER		DUE TO, OR AS A CONSEQUENCE OF (c) PREDNISONE THERAPY AND BREAST CANCER	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:	
RHEUMATOID ARTHRITIS		RHEUMATOID ARTHRITIS		RHEUMATOID ARTHRITIS		RHEUMATOID ARTHRITIS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/31 1984, to 9/1 1984, that (I) (we) last saw the deceased alive on 9/1 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED			
		Patricia A. Savadel MD		9/2/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED			
PATRICIA A. SAVADEL		7600 OSLER DR. SUITE 200 TOWSON MD 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		Sept. 4, '84		Parkwood Cemetery		Baltimore Co., MD	
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR	
NAME ADDRESS		NAME ADDRESS		NAME ADDRESS		NAME ADDRESS	
William E. Johnson		8521 Loch Raven Blvd.		SEP 4 1984		Lelia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 6 4 2 3 7 3 4

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Edith		M.		O'Connell	Sept. 18, 1984				M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 72 HRS.	
Female	White		Jan. 1, 1910		74	YRS.	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.				Baltimore County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson	Meridian Mult. Medical Center				Secretary Ret.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland				Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3133 Lawnview Ave. 21213		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Not Known		McCausland		Not Known					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		215-10-5263		Isabelle A. Burell 3133 Lawnview Ave. 21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral pulmonary arrest</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Anteriorly placed heart valve</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Heart failure</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Anteriorly placed heart valve</i> (b) <i>Generalized atherosclerosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
N/A		N/A		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1981</i> to <i>Sept 1984</i> , that (I) (we) last saw the deceased alive on <i>August 1984</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Alfonso H. Janoski</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/18/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Dr. Alfonso H. Janoski M.D.		Franklin Square Hosp. Rossville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Sep 19 1984		Most Holy Redeemer		Baltimore Maryland			
24. FUNERAL DIRECTOR NAME				25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc. Baltimore, Maryland				SEP 21 1984		<i>John Davidson</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

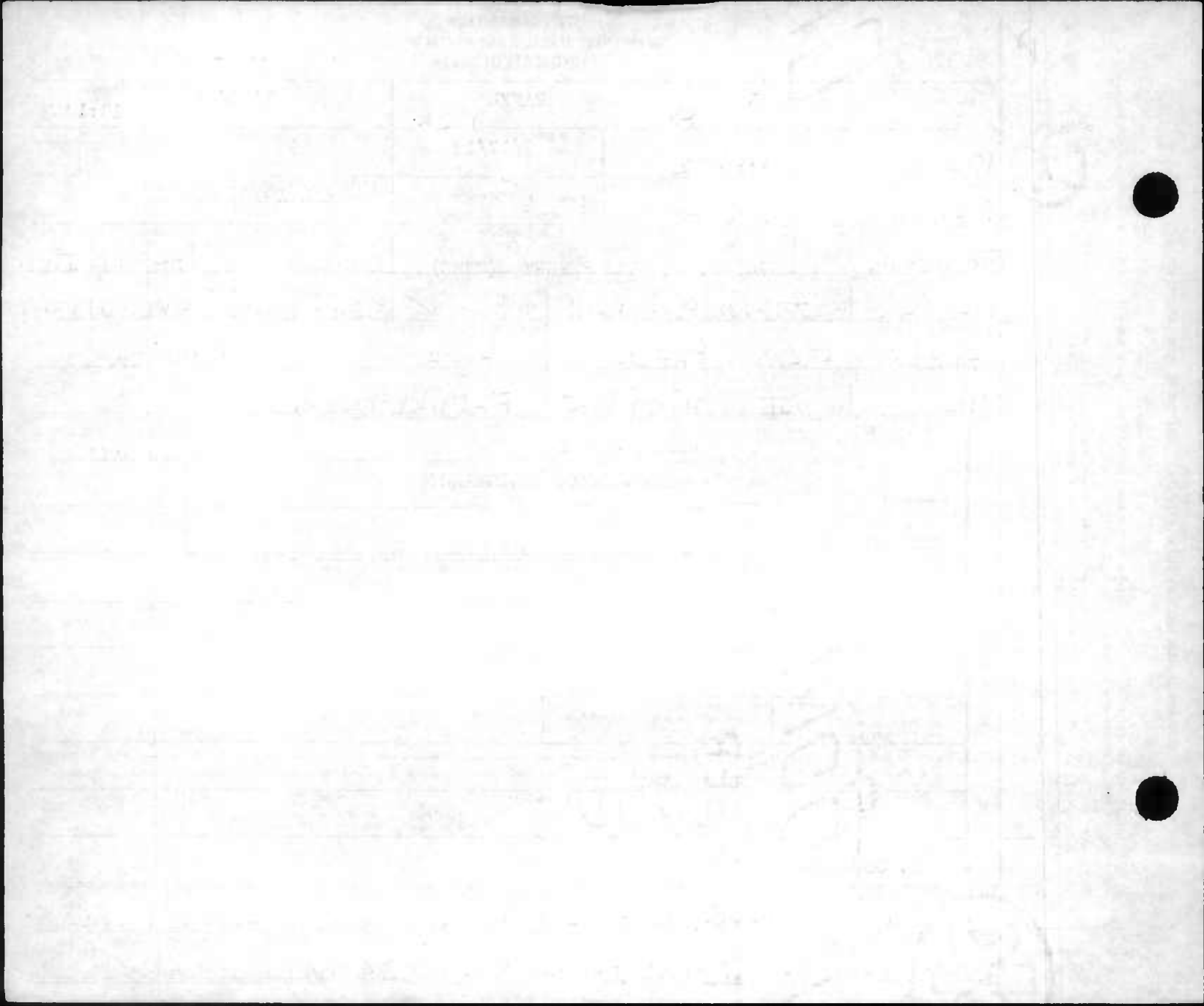
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY A. PAFEL SR.			2a. DATE OF DEATH MONTH DAY YEAR 9/10/84		2b. HOUR 10:10AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 5/17/18	6. AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N. CHARLES STREET (GBMC)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER	12b. KIND OF BUSINESS OR INDUSTRY HARCON Inc	
13a. STATE Maryland		13b. COUNTY BALTIMORE	13c. CITY OR TOWN PERRY HALL	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9544 BAUSER AVE. 21236
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT FRANK PAFEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA Himmer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. 12093765	17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERCALCEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC MALIGNANCY</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 9-6	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 84 9-10 84			
22a. I certify that (I) (this hospital) attended the deceased from 9-10 84, 1984, to 9-10 84, 1984, that (I) (we) lost saw the deceased alive on 9-10 84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE T. O'Donnell			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. O'DONNELL			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9-13-1984	23c. NAME OF CEMETERY OR CREMATORY BEL AIR Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR HARFORD MARYLAND		
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIALS			25a. DATE REC'D. BY REGISTRAR SEP 24 1984		
ADDRESS 8800 HARFORD ROAD			25b. REGISTRAR'S SIGNATURE John Switzer-Rodell		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic agent, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

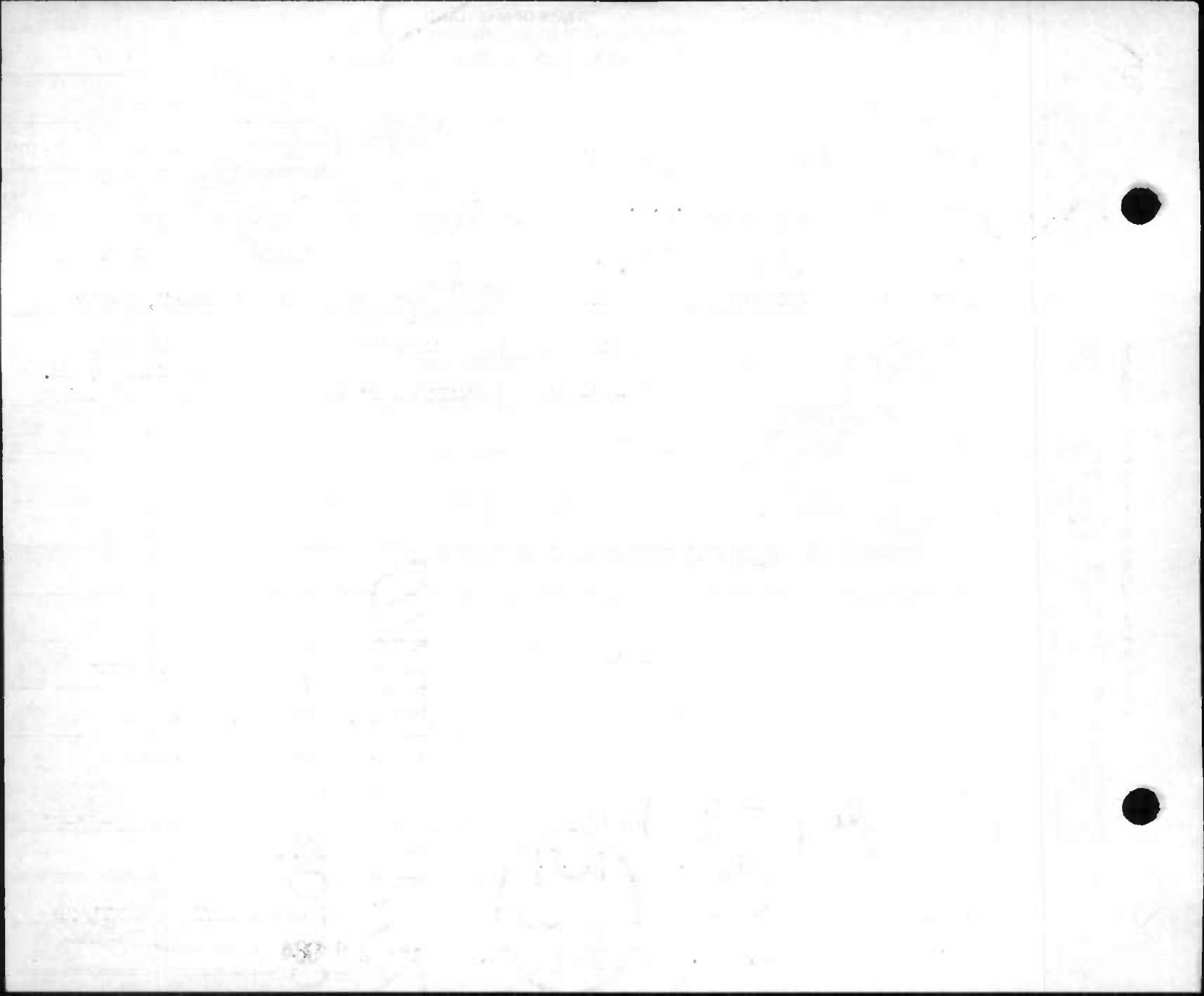
1. DECEASED NAME (TYPE OF PRINT) FIRST MIDDLE LAST <b>Lillian R. Palmer</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>September 26, 1984</b>		2b. HOUR <b>1 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 10, 1912</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>72</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT BY SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley View Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operator</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Morris Lemuel Taylor</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Webb</b>		16. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		18b. SOCIAL SECURITY NO. <b>212 03 6575</b>		17. INFORMANT ADDRESS <b>Jane Lynn Enos 8718 Roper Road 21234</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>Peptic ulcer - NG tube feeding</b>					
19a. DATE OF OPERATION <b>9/29/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>84</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6331 Belair Rd Balto 21206</b>	
22a. I certify that (1) (the deceased) died from <b>9/29/84</b> to <b>9/26/84</b> that (2) (the deceased) was alive on <b>9/29/84</b> and that (3) (my) opinion death occurred on the date and hour and from the causes stated above, (4) (I have) (and) not view the body after death.					
22b. SIGNATURE <b>Dr. Vuong Nguyen</b>		22c. DATE SIGNED <b>9/27/84</b>		22d. PHYSICIAN'S NAME (TYPE OF PRINT) <b>Dr. Vuong Nguyen</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/29/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Burgee-Henss Funeral Home, Baltimore, Md. 21211</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn, Balto. Co., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 28 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Davidson</b>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 23737					
1- FOR STATE REGISTRAR												2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
ALEKSANDRA						PAPLONSKIS						2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
FEMALE		WHITE		10 26 19		64 YRS.		MONTHS DAYS		HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH					
LITHUANIA				U.S.A.				WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore County					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Arbutus				1203 Swallow Ct.				SEAMSTRESS				CLOTHING					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MARYLAND				BALTIMORE		ARBUTUS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1203 SWALLOW COURT, 21227							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
BRONUS						MIKELKITIS						PETRONELE UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						212-30-0110						LINTHICUM, MD. ALGIRDAS PAPLONSKIS 402 HILLVIEW DRIVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Hanging</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>																	
(c) <u></u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				5:10 PM MON 9-26-84				subject found hanging from garage door									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				garage				1203 Swallow Ct. Arbutus, Maryland									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
<i>Margarita A. Korell</i>				M.D. Assistant				MEDICAL EXAMINER				9-27-84					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Margarita A. Korell, M.D.				111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
BURIAL				09-29-84		LOUDON PARK				BALTIMORE CITY MARYLAND							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
HUBBARD FUNERAL HOME, INC.				4107 WILKENS AVE.				SEP 28 1984				<i>Julia Davidson-Handell</i>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY C. Pariseau</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9/6/84</b>				2b. HOUR <b>1<sup>30</sup> A M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 24 20</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS.</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella MARIS Hospice</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office Worker-Monumental Ins.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>300 S. Augusta Ave. #21229</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip A. Muller</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine M. McCarron</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-14-7144</b>		17. INFORMANT ADDRESS <b>Robert Henry 301 S. Augusta Ave. #21229</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LIVER METASASIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PROBABLE PANCREATIC CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/29</b> 19 <b>84</b> , to <b>9/6</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Kendall R. Faulkner MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>9/6/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kendall R. Faulkner</b>				22e. ADDRESS <b>Stella MARIS Hospice</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9-7-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>G. Truman Schwab</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>			

BP

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RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23139							
FOR 1 - STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Lester C. PARKER				2a. DATE OF DEATH MONTH DAY YEAR Sept. 1, 1984				2b. HOUR 1:10 A.M.									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-2-09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.											
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Md.										13b. COUNTY Baltimore		13c. CITY OR TOWN Marriottsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21104 Wards Chapel Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Columbus PARKER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA Ridgley													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215 05 1997		17. INFORMANT ADDRESS CARROLL PARKER - Reisterstown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure delay dialysis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several weeks Several weeks																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 19 84, to Sept 1, 19 84 that (I) (we) last saw the deceased alive on Sept 1, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (she) (did not) view the body after death.																	
22b. SIGNATURE [Signature]				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/1/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SEYMOUR H. RUBIN				22e. ADDRESS 7111 Park Heights Ave. 21215													
23a. BURIAL, CREMATION, REMOVAL (BY TYPE) Burial				23b. DATE 9-3-84		23c. NAME OF CEMETERY OR CREMATORY Old Oakland Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.							
24. FUNERAL DIRECTOR [Signature] W. Haight				ADDRESS Sykesville, Md.				25. DATE REC'D. BY REGISTRAR SEP 5 1984				25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

23740

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CONSTANTINE J. PECUNES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT. 29 1984</b>		2b. HOUR <b>6 19 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 01 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tobacco Distributor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>BALTO</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1004 CONCORDIA DRIVE 21204</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dimitrios Pecunes</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vasiliki Papoudis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-07-4030</b>		17. INFORMANT ADDRESS <b>Theodora Pecunes, Same as 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Pulmonary A. Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Angina Pectoris</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary Edema</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b> <b>2 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 78</b> to <b>Sept 29 19 84</b> , that (I) (we) last saw the deceased alive on <b>Sept 29 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.					
22b. SIGNATURE <b>Bernard S. Karpman J.M.D.</b>				22c. DATE SIGNED <b>9/29/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD S. KARPMAN J.M.D.</b>				22e. ADDRESS <b>107 PROFESSIONAL ARTS BLD BALTO, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>10-2-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox</b>	
23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 1 1984</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

BP



Continued on J. Form 1-24-62

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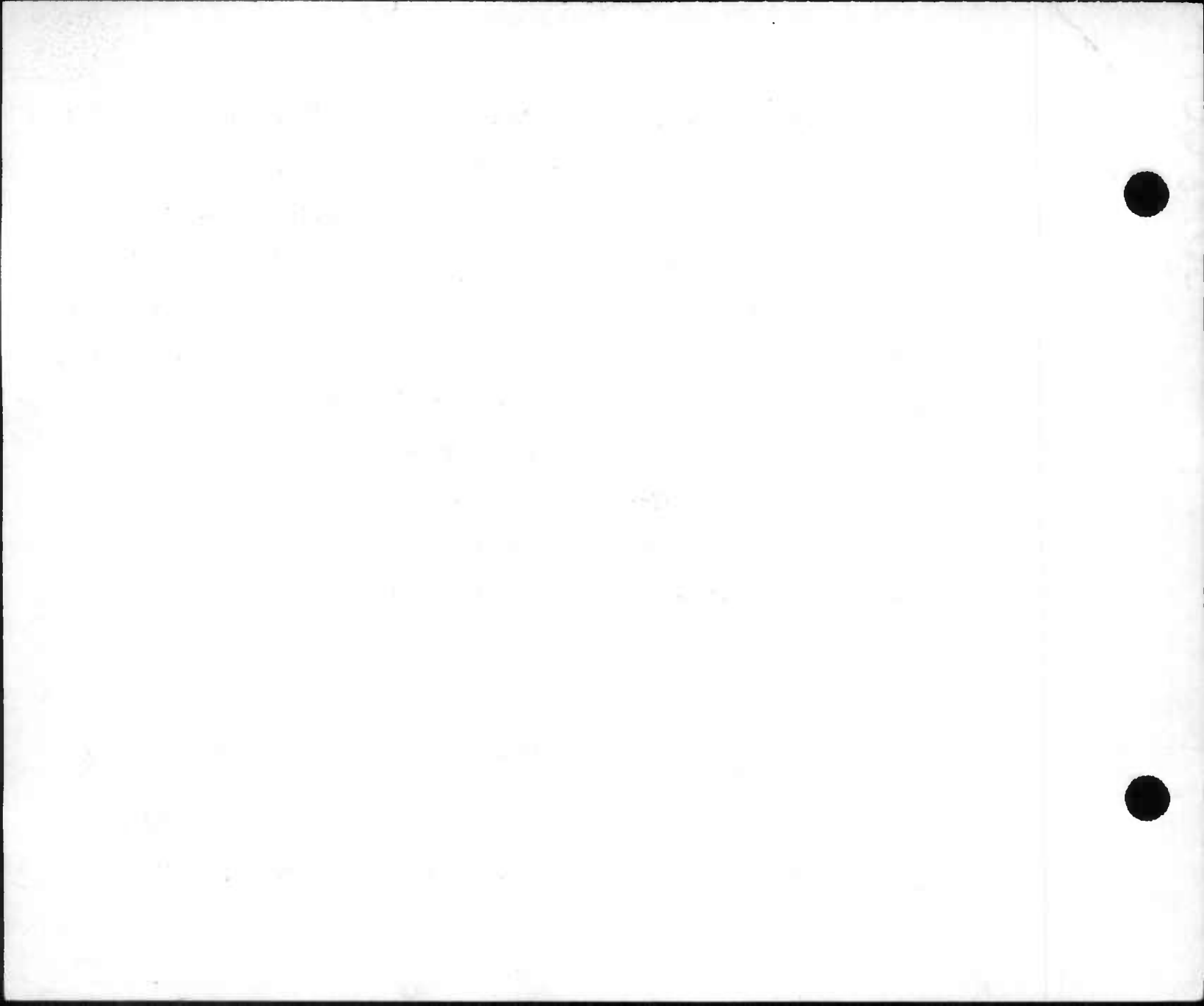
Continued on J. Form 1-24-62

Continued on J. Form 1-24-62

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 6423141

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Helen Ethel PERUSSE		2a. DATE OF DEATH MONTH DAY YEAR September 3, 1984		2b. HOUR 10:31AM	
3. SEX F		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 2 29 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HSWR		12b. KIND OF BUSINESS OR INDUSTRY —	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 815 DORSEY AVE 21221	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES E. MADDOX		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA BLANCHE EDWARDS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-01-9311		17. INFORMANT ADDRESS DOROTHY CHENOWETH 21027 12409 EASTERN AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus with Peripheral Vascular Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from August 27, 1984, to September 3, 1984, that (we) lost saw the deceased alive on above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D. Jann		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 97 3/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Jann		22e. ADDRESS 9000 Franklin Square Dr. 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/6/84		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME CONNOLLY F.H.		ADDRESS 300 MACE AVE.		25a. DATE REC'D. BY REGISTRAR SEP 7 1984		25b. REGISTRAR'S SIGNATURE K. J. Randall			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elizabeth C. Petrick</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9-12-84</i>			2b. HOUR <i>7:45 AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 23 99</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>84</i> <i>11</i> <i>10</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto., MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County MD</i>			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Manor Care Nsg. Center</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>MD</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>501 S. Marlyn Ave. 21221</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Francis Vanicek</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Barbara Stanek</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-09-0249</i>		17. INFORMANT ADDRESS <i>Mrs. Elizabeth M. Jubb, 501 S. Marlyn Ave., Balto., 21221</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Many yrs 15+</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several months</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic GI Recurrent</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>19 69</i> to <i>Sept 12</i> 19 <i>84</i> , that (we) last saw the deceased alive on <i>12 Sept 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John C. Hyle</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>13 Sept 84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN C. Hyle</i>				22e. ADDRESS <i>7527 Belair Rd Balto 21236 Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Type or Print) <i>Burial</i>		23b. DATE <i>9/15/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Balto. MD</i>			
24. FUNERAL DIRECTOR NAME <i>John C. Miller, Inc. 6415 Belair Rd. 21206</i>						25a. DATE REC'D. BY REGISTRAR <i>SEP 13 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>	

MEDICAL CERTIFICATION

1

10

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23743

FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO. <span style="font-size: 1.5em; font-weight: bold;">23743</span>	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR	2b. HOUR
Peter Scott Phillips JR.						ESTIMATED <input type="checkbox"/> 9/13/84			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		2d. HOUR
MALE	WHITE	9 22 1961		22 YRS.	MONTHS	DAYS	9/13/84		2:45 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				Baltimore County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Essex		Intersec. Margaret & Virginia Ave.				SHEET METAL		HARE BROS.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS			
BALTIMORE		MARYLAND	BALTIMORE	ESSEX		141 LANGLEY RD 21221			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
PETER PHILLIPS		VIRGINIA MC AVOY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		220 82 2200		VIRGINIA PHILLIPS 141 LANGLEY RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
8122 IMMEDIATE CAUSE (a) Multiple Injuries									
(b) _____ DUE TO, OR AS A CONSEQUENCE OF									
(c) _____ DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
		2:00am 9/13/84		subject driver of motorcycle/auto collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
		street		Intersec. Margaret & Virginia Ave., Balto. Co., MD.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 9/13/84			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
Gregory R. Kauffman, M.D.		111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SICILY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN) COUNTY STATE					
BURIAL	9-15-1984	OAKLAWN		BALTIMORE MD.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
RAYMOND L. KACZOROWSKI		FLEET ST. 2525		SEP 17 1984		<i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
FRANCES I PICKETT				9-12-84		9:30PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE		WHITE		6 MONTH 6 DAY 17		67		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md		Usa				BALTIMORE COUNTY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		GBMC 6701 N CHARLES ST		telephone oper		telephone			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md		Carroll		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		82 1/2 E. Main st 21157	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Earl		Tucker		Mary		Franklin			
no		n/a		215-14-2547		Dillon Pickett Arbutus, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY FAILURE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE KIDNEY FAILURE</u>								23 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CERVICAL CA</u>								1 YEAR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>84</u> , to <u>9/12</u> , 19 <u>84</u> that (I) (we) last saw the deceased alive on <u>9/12</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<i>DR. W. KOBASA</i>						MD		9/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
DR. W. KOBASA						GBMC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
burial		9/15/84		Taylorsville		Taylorsville Carroll Md			
24. FUNERAL DIRECTOR						25a. DATE REC'D BY REGISTRAR			
<i>Funeral Home</i>						SEP 20 1984			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 7 4 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARGUERITE M POHLER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9/29/84</b>				2b. HOUR <b>4:55 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 7 91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N CHARLES ST GBMC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balt</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>615 Chestnut Ave. 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Holdefer</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Weitzel</b>				ADDRESS <b>401 Wingate Road</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-24-0294</b>		17. INFORMANT <b>Mr. George T. Bertsch</b>		ADDRESS <b>Balto., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFECENCY</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION <b>9/26/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>HEAD RL HIP EXCISION OF FEMORAL</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1) OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/22</b> , 19 <b>84</b> , to <b>9/29/</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Uberoi</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. K. UBEROI</b>				22e. ADDRESS <b>GBMC</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>9/30/84</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Anatomy Board Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 2 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

MEDICAL CERTIFICATION



RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

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ALL INFORMATION CONTAINED

EX-101 JAN 15 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

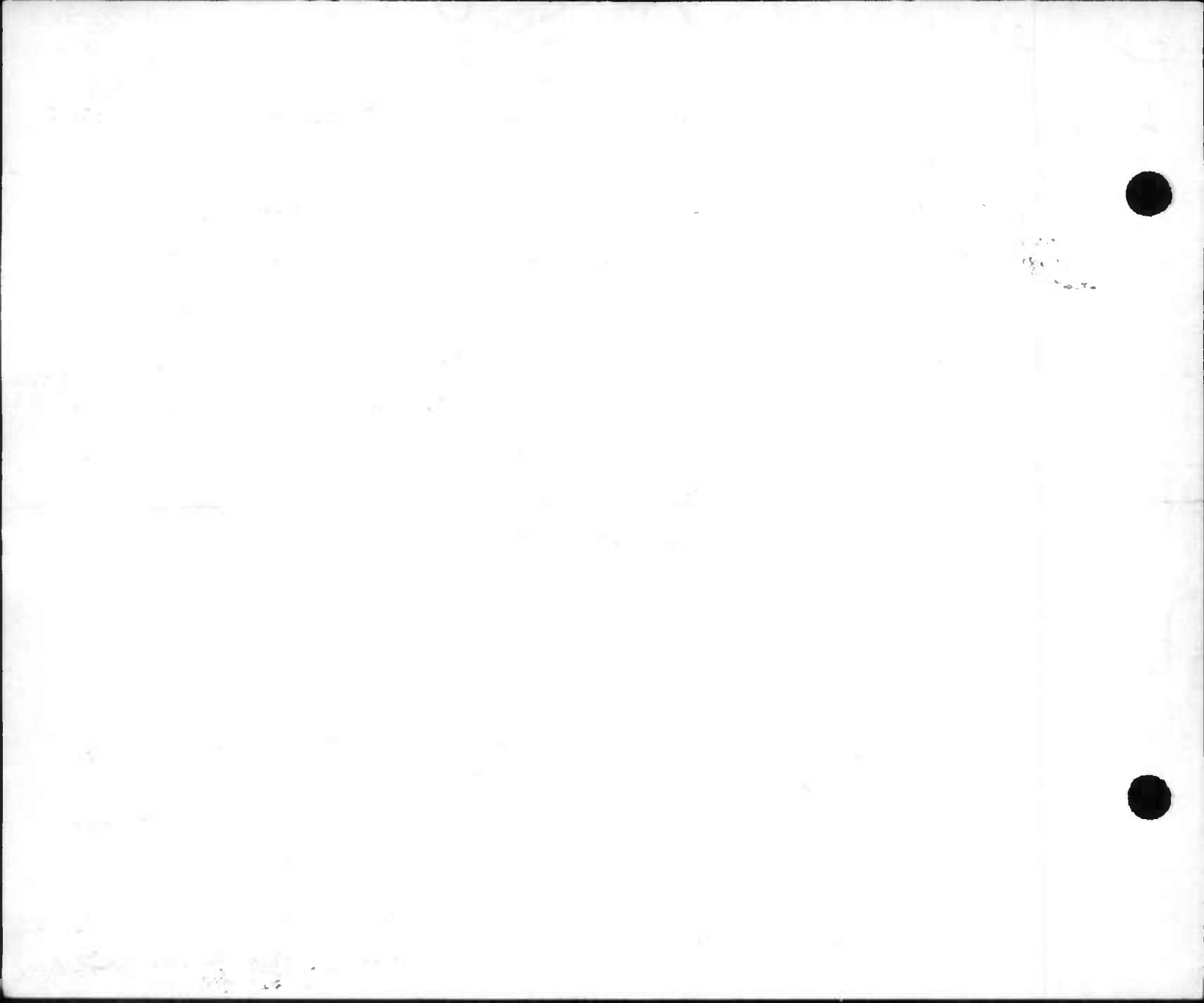
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 / 4 6

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Joseph G. POLLHEIN		September 17, 1984		1:35 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	5 17 1909	75 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Rossville	Franklin Square Hospital	Machinist	American Can		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Dundalk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Apt. B-3 21222	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
George Joseph Pollhein	Mary Booker	217-03-4283			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
No	217-03-4283	Elizabeth A. Watson-Balto., MD. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Bacterial Pneumonia					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) Pneumoconioses					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Metastatic Carcinoma					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 5, 1984 to September 17, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on September 17, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Keith English MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		9/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
KEITH ENGLISH		9000 Franklin Square Drive, 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. COUNTY STATE	
Burial	9/20/1984	Gardens Of Faith	Baltimore	Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Duda-Ruck, Inc.		SEP 21 1984		Julia Davidson-Randall	
7922 Wise Avenue Dundalk, MD. 21222					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 4 2 3 1 4 7			
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE W. POLLOCK</b>				7a. DATE OF DEATH MONTH DAY YEAR <b>9 18 84</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 14 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS Hospice</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clothing Cutter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Howard Uniform</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Pollock</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Carroll</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-09-1796</b>		17. INFORMANT ADDRESS <b>K. Annetta Pollock - Same as #13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive pulmonary disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lung Cancer with pleural effusion</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased on <b>September 18 19 84</b> to <b>September 19 84</b> , that (I) (we) last saw the deceased alive on <b>September 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>H. Faulkner MD</b>				DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-21-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium, Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>				ADDRESS <b>1050 York Rd. Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>			

BP



Maryland

U.S.A.

x

Georgetown Center Howard Union

107 Springdale Dr. 21083

Carroll

Hillie

Pollock

W.

George

215-02-1795 E. Annette Pollock - same as #136

to

Thonon, Baltimore, Maryland

Baltimore Valley

9-21-84

Initial

Post Office Funeral Home, Inc. Towson, Md. 21204  
100 York Rd.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 7 4 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ethel Margaret POOLE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 8, 1984</b>		2b. HOUR <b>12:03PM</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 18 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>90</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>			
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKING</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>991 Seneca Park Rd.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lucias Blanchard</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mollie Taylor</b>				ADDRESS <b>21220</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-09-1391</b>		17. INFORMANT ADDRESS <b>Ethel F. Covington 911 Seneca Park Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Renal Insufficiency, Hyperglycemia, Dehydration</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-5</b> 19 <b>84</b> to <b>9-8</b> 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9-8</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (I) (did not) view the body after death.									
22b. SIGNATURE <i>Thomas Lampone M.D.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>9-8-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas Lampone, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-10-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>LASCAHN Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment must be retained by the hospital or attending physician.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8423749

REG. NO.

FOR  
STATE  
REGISTRAR

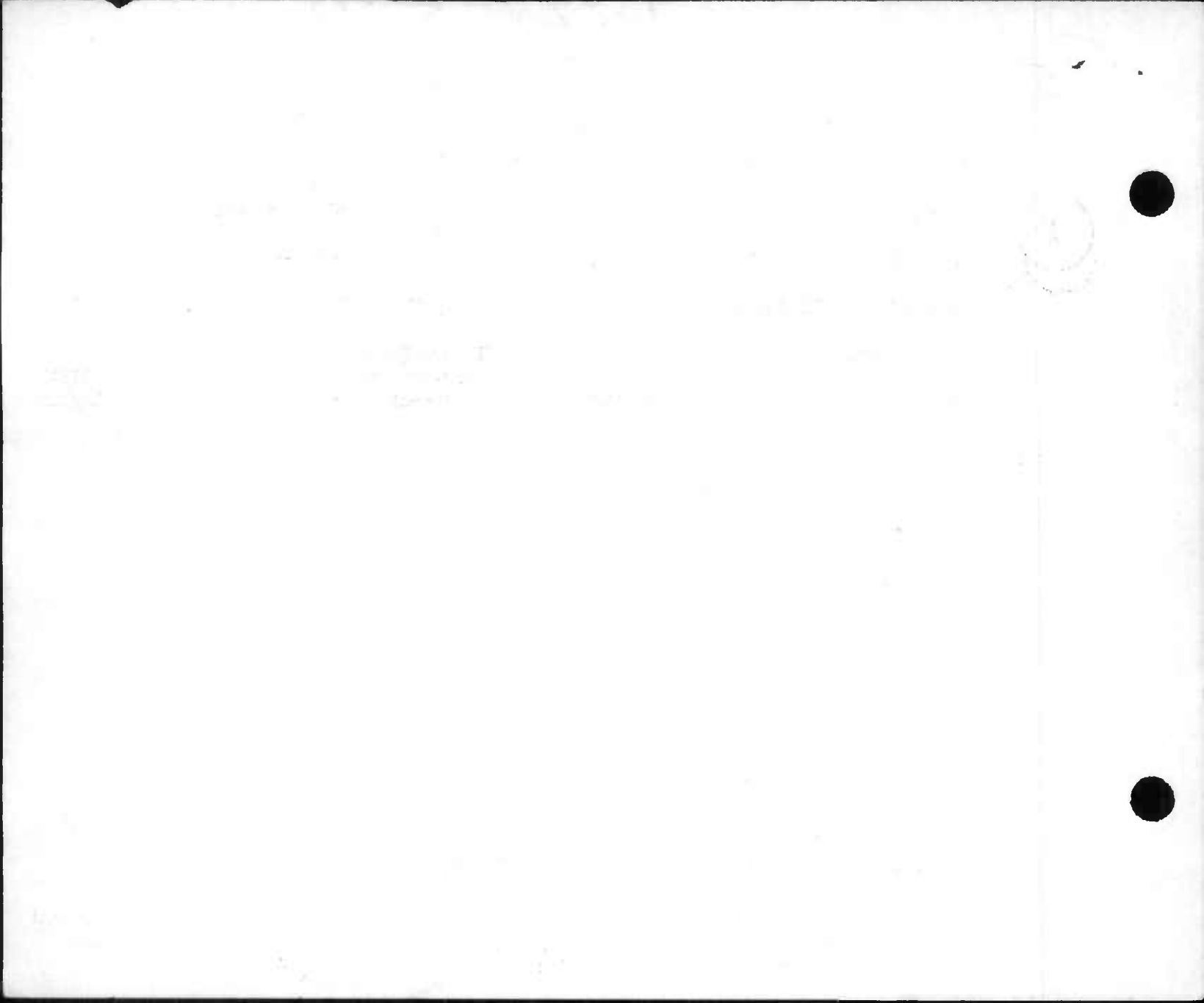
1 DECEASED NAME (TYPE OR PRINT) <b>C. Ruth Powers</b>			2a DATE OF DEATH MONTH DAY YEAR <b>September 25 1984</b>		2b HOUR M
3 SEX <b>Female</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>January 14 1900</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10 CITY OR TOWN OF DEATH <b>Woodlawn</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1923 Hillcrest Rd.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Woodlawn</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>1923 Hillcrest Rd. 21207</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Wilford Ecker</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Heath Ecker</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>215-54-1259</b>	17 INFORMATION <b>Mrs. Betty Hughart</b>		ADDRESS <b>3320 Courtleigh Drive Baltimore Maryland 21207</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction with</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cardiorespiratory Arrest.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Old Myocardial Infarction</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>October 19 69</b> to <b>September 19 84</b> , that (we) lost saw the deceased alive on <b>Sept 24 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (or) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Herman Brecher</b>		DEGREE <b>Attending Physician</b>		22c DATESIGNED <b>9/26/84</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Herman Brecher</b>		22e ADDRESS <b>6410 Windsor Mill Road</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>9/28/84</b>	23c NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>		ADDRESS <b>8728 Liberty Road Randallstown, Maryland 21133</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 28 1984</b>	25b REGISTRAR'S SIGNATURE <b>Jana Waldson-Randall</b>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

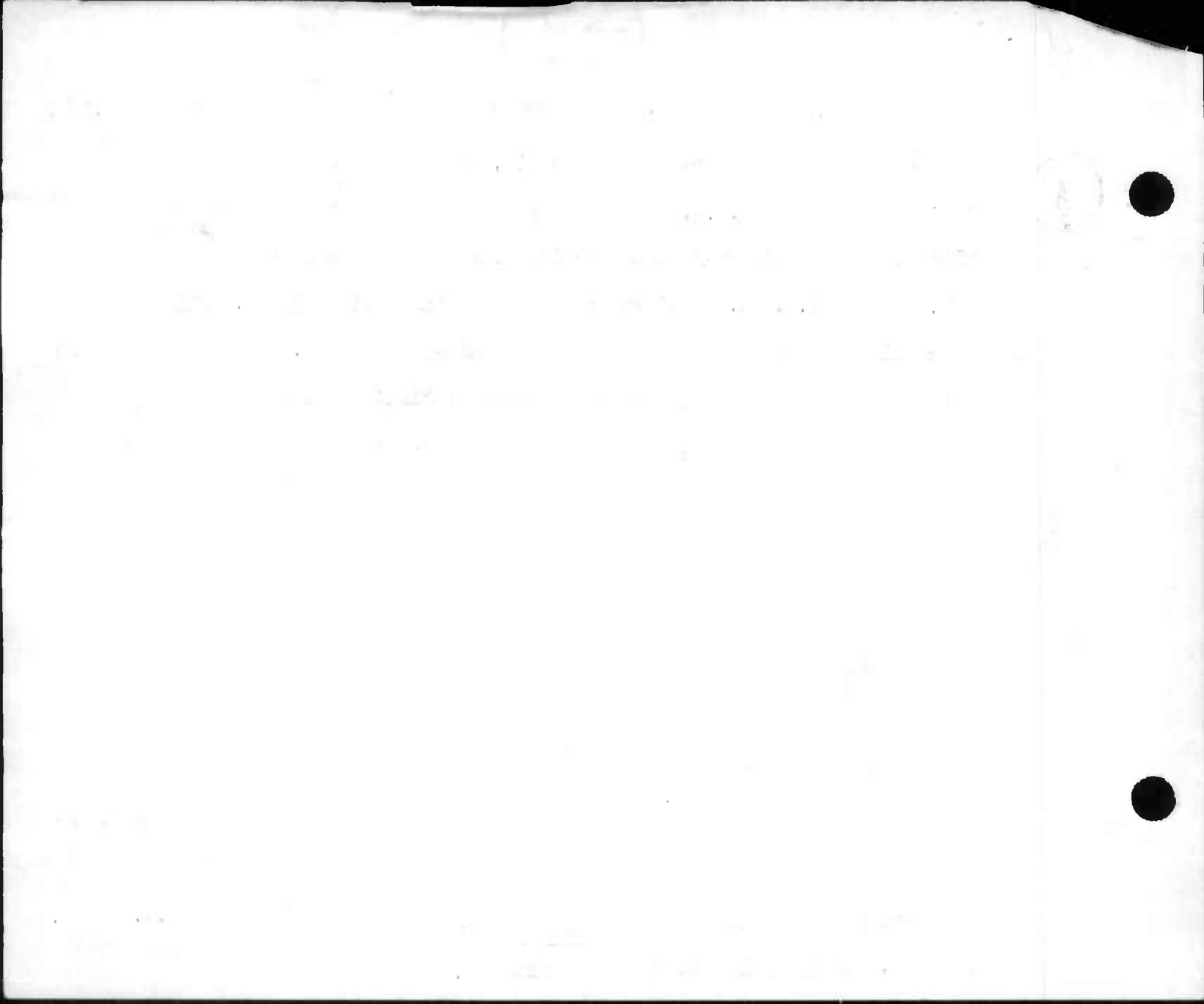
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Store Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 4 2 3 / 5 0		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Macye B. Presley</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9 25 84</b>		2b. HOUR <b>9:15 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 13, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Ridgeway Manor Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Riviera Bch</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>210 Dale Rd. 21122</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>McNeil Brooks</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sally E. Yost</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214 74 4460</b>		17. INFORMANT ADDRESS <b>Betty Lambiasi same as 13 e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 15, 19 81</b> to <b>SEPT 25, 19 84</b> , that (I) (we) last saw the deceased alive on <b>SEPT 25, 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Norman Kleiman</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9/26/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NORMAN R. KLEIMAN</b>		22e. ADDRESS <b>3803 EDMONDSON AVE BALTO MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/29/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy Balto Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24-hour office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

4 2 3 7 5 1

1. DECEASED NAME (TYPE OR PRINT) <b>REV. GEORGE J. PUGH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 6, 1984</b>		2b. HOUR M <b>AM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 6, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Dundalk</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6736 Youngstown Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Roman Catholic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Priest</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Dundalk</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George J. B. Pugh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine A. Feeley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-10-9683</b>		17. INFORMANT ADDRESS <b>Miss Marie T. Pugh 6210 Haddon Ave, 21212</b>		
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO-SCLEROTIC CARDIO-VASC DIS.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5 years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSIVE CARDIO-VASC DIS</b> <b>13 years</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>12134 9/6 SE</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>12/13/84</b> , 19 <b>84</b> , to <b>9/6</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>8/3/84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Irvin Kaplan MD</b>				22c. DATE SIGNED <b>9/7/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Irvin Kaplan, M.D.</b>				22e. ADDRESS <b>129 Broadway</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/10/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>1050 York Road</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b>		
				25b. REGISTRAR'S SIGNATURE <b>John Davidson Handell</b>		

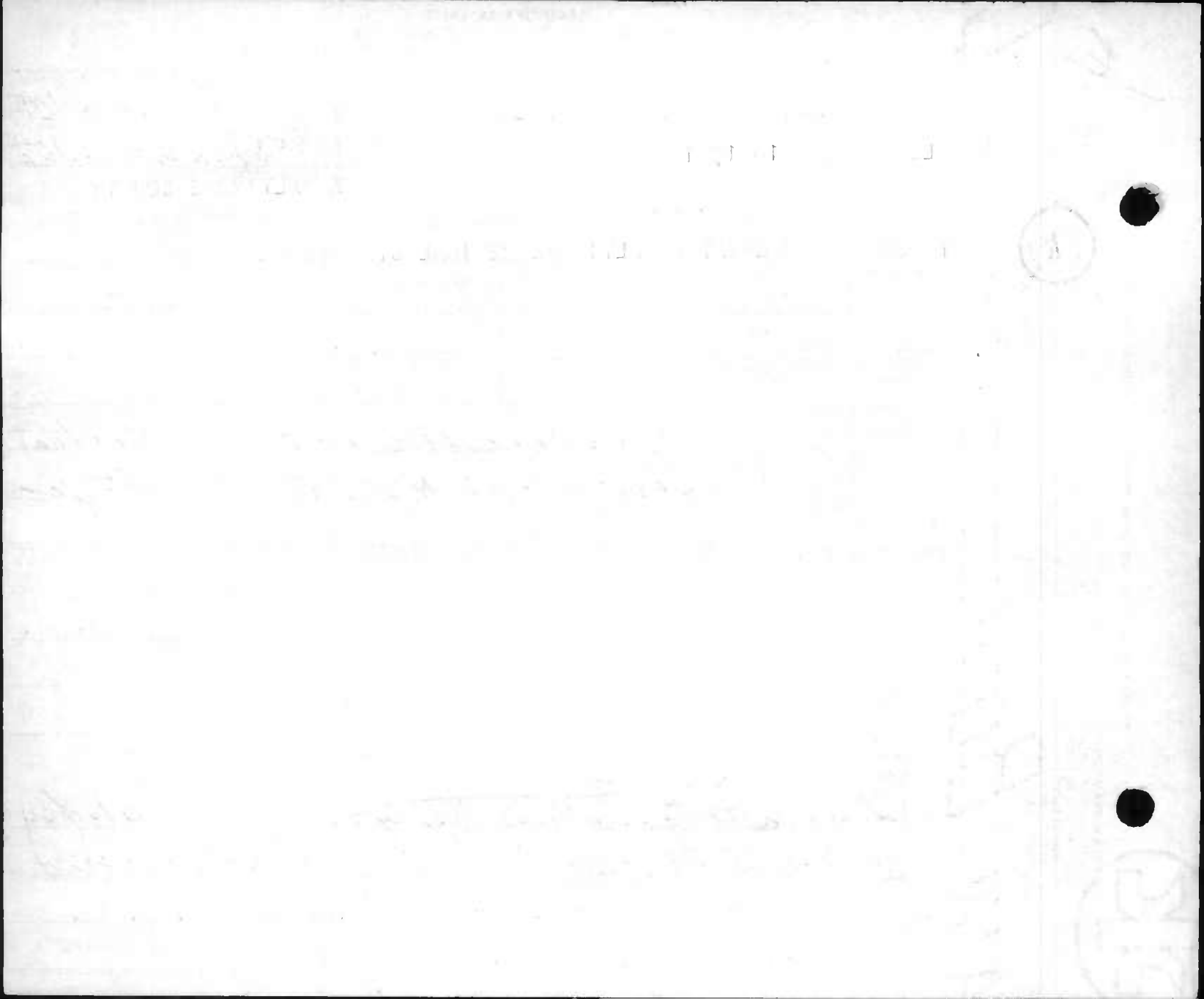


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23752	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE J. PULHAM										2b. DATE ESTIMATED September 30, 1984	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 17 1894		6. AGE (IN YEARS) (LAST BIRTHDAY) 89 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD September 30, 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CTR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personnel Clerk		12b. KIND OF BUSINESS OR INDUSTRY VA Hospital	
13a. STATE Md										13b. COUNTY --	
13c. CITY OR TOWN Baltimore										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3838 Roland Avenue 21211											
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Johnson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma M. Hoshall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218 32 9560				17. INFORMANT ADDRESS Elaine Brown 4111 Buena Vista Avenue 21211			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordone arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>Generalized ASCVD</u> (b) <u>5+ yrs</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> Deputy						MEDICAL EXAMINER			DATE SIGNED <u>9/30/84</u>		
EXAMINER'S NAME (TYPE OR PRINT) <u>CHARLES F O'Donnell</u>						ADDRESS <u>7501 York Rd - Towson 21204</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/2/84		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Eastpoint Balto. Co. Md.	
24. FUNERAL DIRECTOR NAME Burgee Funeral Home						ADDRESS 3631 Falls Road 21211			25a. DATE REC'D. BY REGISTRAR OCT 3 1984		
						25b. REGISTRAR'S SIGNATURE <u>Johia Davidson-Randall</u>					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

4 23753

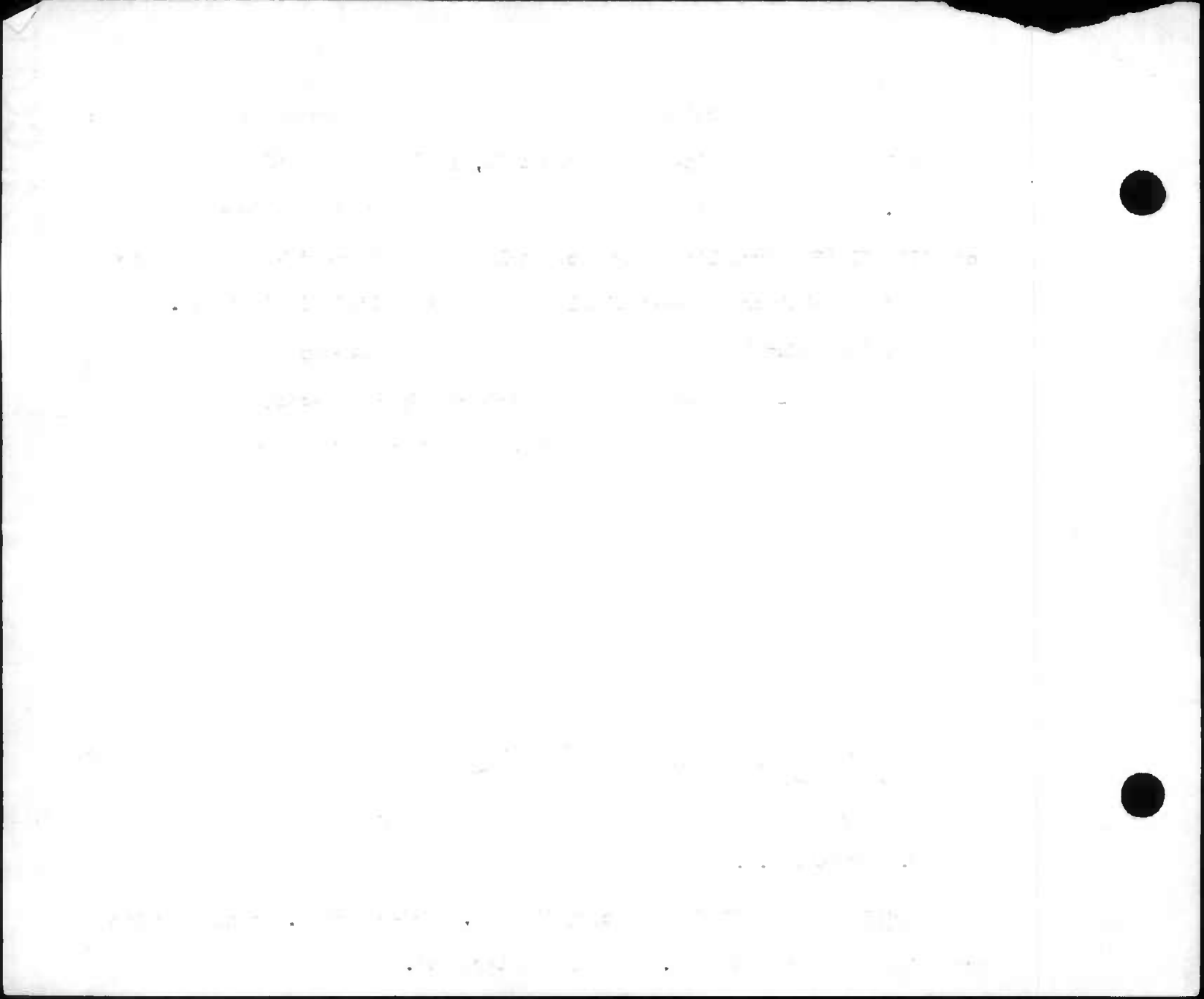
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		FIRST MIDDLE LAST <b>Thelma Louise Raborg</b>		MONTH DAY YEAR <b>September 4, 1984</b>		HOURS MIN. <b>8:45a M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 22, 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>58</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Rossville 21237</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex 21221</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Caldwell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		13e. STREET ADDRESS / ZIP CODE <b>1550 Williams Ave. 21221</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>209 20 6049</b>		17. INFORMANT ADDRESS <b>Richard Raborg (same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 4, 1984</b> , to <b>September 4, 1984</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>September 4, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did not) view the body after death.							
22b. SIGNATURE <i>M. Darwish</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>September 4, 1984</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Darwish, M.D.</b>		22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/7/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Hill Mem. Gardens Balto. County Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <i>Bruzdinski Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <b>SEP 6 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (in one of the following ways):

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frederick C RASMUSSEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 14, 1984</b>		2b. HOUR <b>7:45 A.M.</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8/13/12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>M.D.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQ.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>M.D.</b>	13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>ESSEX</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>107 N. STUART ST 21221</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES RASMUSSEN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOSEPHINE BAKER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>UNK</b>		16b. SOCIAL SECURITY NO. <b>21307 7657</b>	17. INFORMANT ADDRESS <b>DOROTHY RASMUSSEN ABOVE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest, Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 20</b> , 19 <b>84</b> , to <b>September 14</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>September 14</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Julio Schwartzman</b>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9-14-84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Julio Schwartzman MD</b>			22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/17/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>J.G. CONNELLY 300 MACE</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 3 7 5 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL REED			2a. DATE OF DEATH MONTH DAY YEAR 9 23 84		2b. HOUR 11:50 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2 19 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) GBMC 6701 N. CHARLES ST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN BALTO.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mitchell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII		16b. SOCIAL SECURITY NO. 213-10-4255		17. INFORMANT ADDRESS Viola Reed 403 S. Robinson St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF ESOPHAGUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/12, 19 84, to 9/23, 19 84, that (I) (we) last saw the deceased alive on 9/23, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward P. Dyer MD				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD GRACE MD				22e. ADDRESS GBMC 6701 N. CHARLES ST, TOWSON MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/26/84		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		23e. DATE REC'D. BY REGISTRAR SEP 26 1984		23f. REGISTRAR'S SIGNATURE Kristen Randall	
24. FUNERAL DIRECTOR NAME ADDRESS KACZDROWSKI FUNERAL HOME 2505 FREEK STREET					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical examiner's report must be attached to this certificate.



*[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

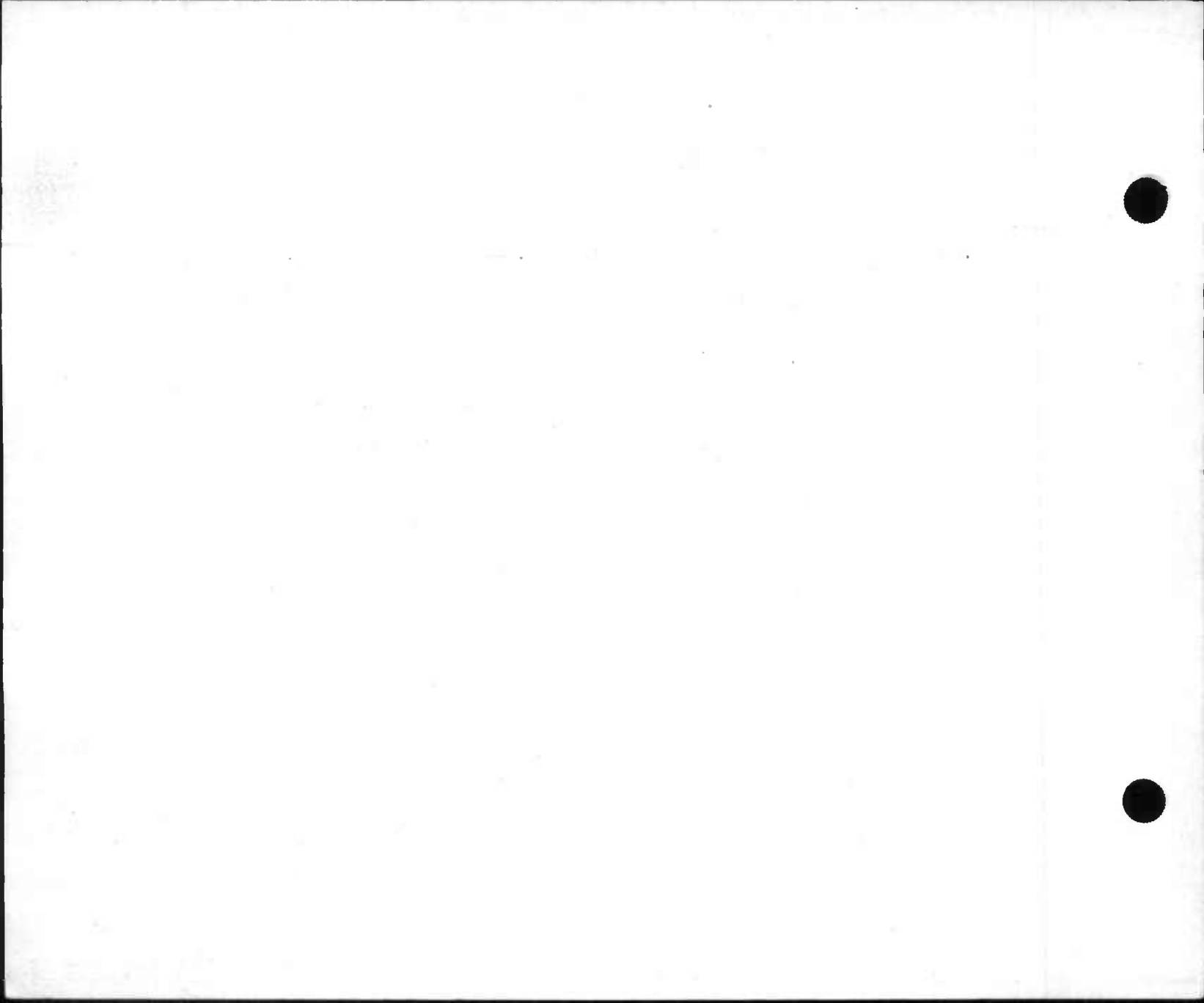
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 20M  
(VRA 15, 4) 7/78STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

4 2 3 7 5 6

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR September 20, 1984		2b. HOUR 6 A.M.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth E. Reid		3. SEX Female		4. RACE Caucasian	
5. DATE OF BIRTH MONTH DAY YEAR 7 20 1927		6. AGE (IN YEARS LAST BIRTHDAY) 57		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	
8. CITIZEN OF WHAT COUNTRY? US		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		10. CITY OR TOWN OF DEATH Catonsville	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Tawes/Bland Bryant Nsg. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) IBM operator		12b. KIND OF BUSINESS OR INDUSTRY Bldg. City	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Rosedale	
14. FATHER'S NAME FIRST MIDDLE LAST Vernon R. Hughes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Pumpfrey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 214 22 4385		17. INFORMANT Carlee Reid		18. ADDRESS 1202 64th St. 21237	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) C.A. of the breast (L) DUE TO, OR AS A CONSEQUENCE OF (c) Metastases					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Modified Radical Mastectomy 1981 (Bosewiers Hosp.)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-6-1977 to 9-20-1984, that (I) we last saw the deceased alive on 9-20-1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
22b. SIGNATURE Cesar Valle Cervero		DEGREE M.D.		22c. DATE SIGNED 9-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR VALLE CERVERO		22e. ADDRESS Spring Grove Hosp. Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9-22-1984		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		24. FUNERAL DIRECTOR NAME John J. Connor & Son Inc 901 Hollins St.			
25a. DATE REC'D. BY REGISTRAR SEP 24 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP



1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Arthur G. Rever Sr.		9 11 84		16:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH	
M		White		5 10 1904	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Towson		Major Care Towson		Accountant	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD		Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS	
John H. Rever		Augusta Foltz		3811 Grenton Avenue-21206	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-01-2430		21234 Mr. Arthur G. Rever Jr.-8534 C Morven Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE				5 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ARTERY DISEASE				15 YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PNEUMONIA, CEREBRAL DEGENERATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 19 72, to 11 years, 19 84, that (I) (we) lost saw the deceased alive on 7-11-84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
23. SIGNATURE				22c. DATE SIGNED	
J. Dixon Hills, MD				12 SEP 84	
23b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
J. Dixon Hills, MD				3501 St. Paul St. Balto. Md. 21218	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9-14-84		Parkwood Cemetery	
24. FUNERAL DIRECTOR		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
John C. Miller Inc-6415 Belair Rd.-21206		Balto. Md.		SEP 13 1984	
25. REGISTRAR'S SIGNATURE				25. REGISTRAR'S SIGNATURE	
[Signature]				[Signature]	



London

11

John H. Brown

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210-01-2130

Mr. Arthur J. Brown Jr. - 2130

2130

Augusta Falls

x

211 Barton Avenue - 2130

Accountant

London

London

21-11-21

Swiss

John J. Miller Inc. - 2130

London

21-11-21

21-11-21



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 4 2 3 7 5 8

1- FOR  
STATE  
REGISTRAR

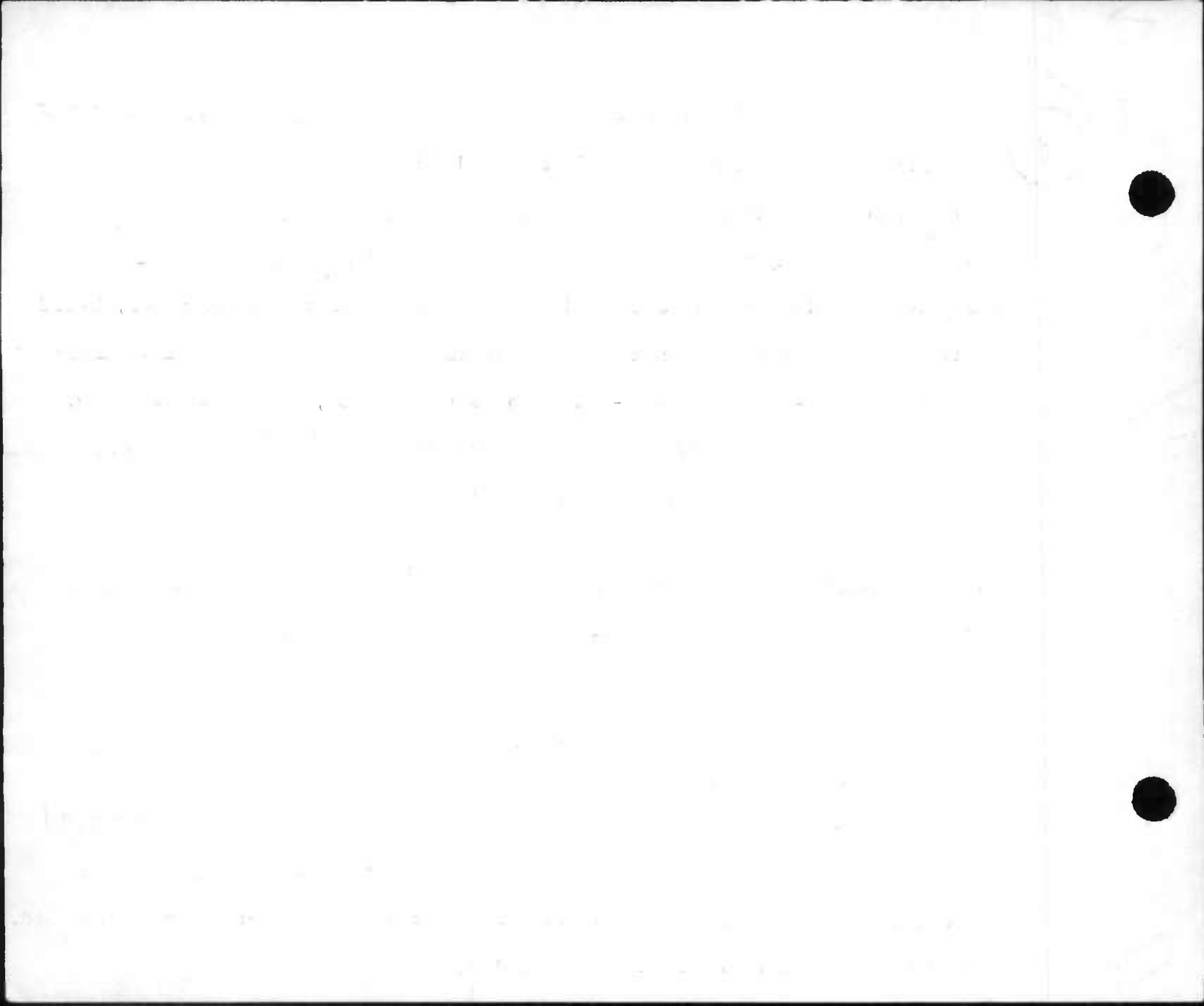
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ERNESTINE Virginia REXROAD</b>			2a DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 27, 1984</b>		2b HOUR <b>3:58A</b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Sept. 22 1912</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b>	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	9b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE County</b> MD.		
10 CITY OR TOWN OF DEATH <b>TOWSON</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a STATE <b>Maryland</b>			13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Cockeysville</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Claude Donald McIntyre</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna May Fazenbaker</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b SOCIAL SECURITY NO. <b>212-68-7537</b>		17 INFORMANT ADDRESS <b>Donna L. Jackson, 10575 Gateridge Rd. 21030</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BACTERIAL ENDOCARDITIS</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SALMONELLA SEPSIS</b>						<b>WEEKS</b>
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a <b>MULTIPLE PROSTHETIC CARDIAC VALVES / PERMANENT PACEMAKER</b>						
19a DATE OF OPERATION <b>-</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>-</b>		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>-</b>		
22a I certify that (this hospital) attended the deceased from <b>SEPT 20</b> 19 <b>84</b> to <b>SEPT 27</b> 19 <b>84</b> , that (we) lost saw the deceased alive on <b>9/27</b> 19 <b>84</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will</del> (did not) view the body after death.						
22b SIGNATURE <b>John J. Jamison</b>				DEGREE <b>MD</b>		22c DATE SIGNED <b>9/27/84</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>John J. Jamison</b>				22e ADDRESS <b>6805 YORK RD ; BALT MD 21212</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>9/29/84</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>L Frederick Frederick Md.</b>
24 FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>				25a DATE RECD. BY REGISTRAR <b>OCT 1 1984</b>		25b REGISTRAR <b>John J. Jamison</b>
24b ADDRESS <b>Martin D. Lawson, 10 W. Padonia Rd. 21093</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified also.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Margaret E. REYNOLDS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 7, 1984</b>			2b. HOUR <b>5:15 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 20 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>213 S. Woodwell Road 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Getzendanner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie M. Chambers</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-26-5441</b>		17. INFORMANT ADDRESS <b>Mary Ann Fleishell Balto., MD. 21222</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac asystole</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia (H. Influenza and Staph aureus)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic liver disease and probable primary lung cancer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>Aug. 30</b> , 19 <b>84</b> , to <b>Sept. 7</b> , 19 <b>84</b> , that (we) lost saw the deceased alive on <b>Sept. 7</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <b>Albert A. Borges</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>9/7/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Albert A. Borges</b>				22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/11/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Duda-Ruck, Inc.</b> NAME ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1984</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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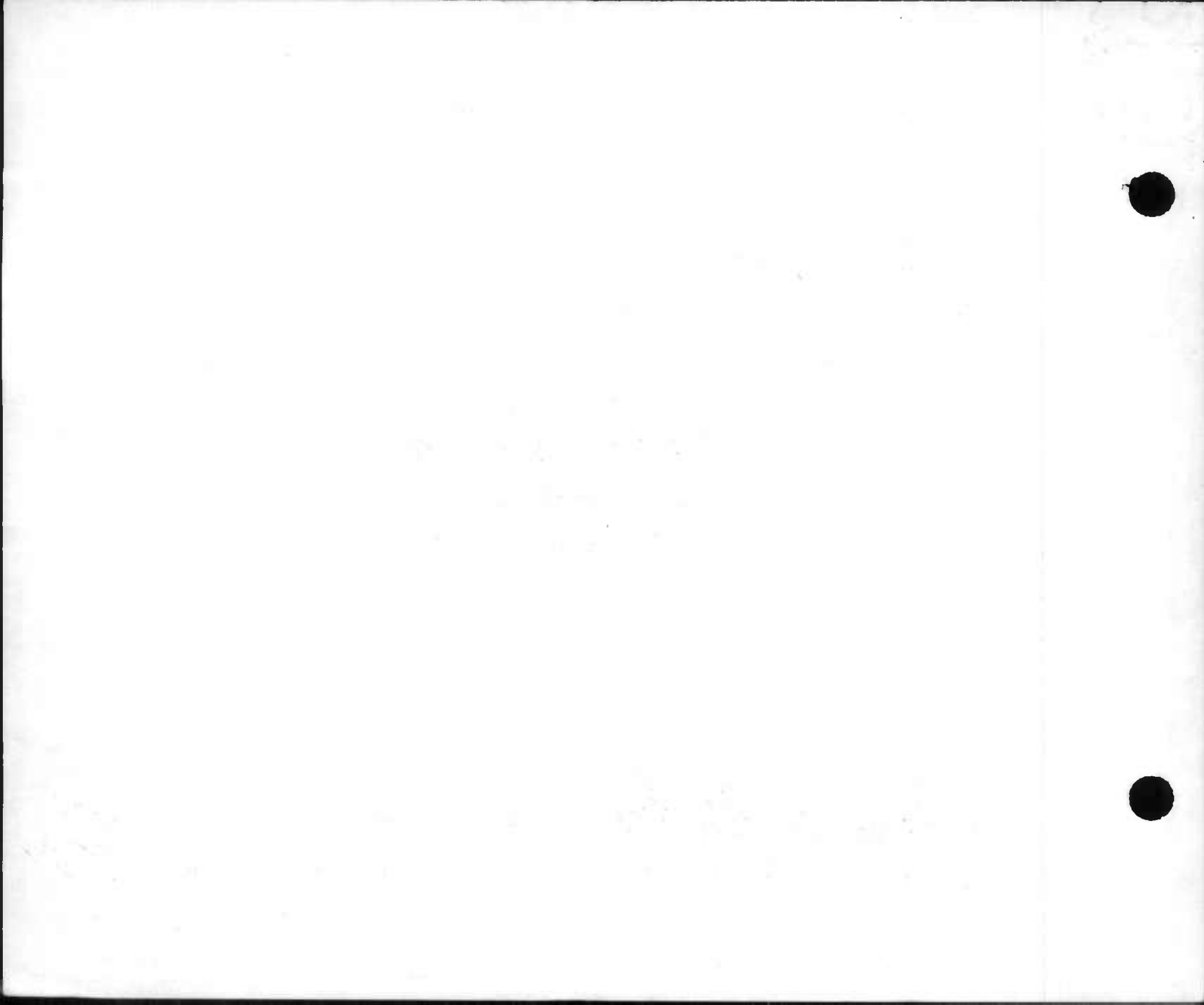
1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> <u>Ruth</u> <sup>MIDDLE</sup> <u>Martha</u> <sup>LAST</sup> <u>Rich</u>				2a. DATE OF DEATH MONTH <u>September</u> DAY <u>1</u> YEAR <u>1984</u>		2b. HOUR M <u></u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>March</u> DAY <u>3</u> YEAR <u>1912</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Parkville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>3010 Hiss Avenue</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Parkville</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>3010 Hiss Avenue 21234</u>	
14. FATHER'S NAME FIRST <u>Edgar</u> MIDDLE <u>S.</u> LAST <u>Fry</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Ann</u> MIDDLE <u>C.</u> LAST <u>Eicholtz</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>218-03-4678</u>		17. INFORMANT ADDRESS <u>Mr. Albert E. Rich Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD - CHF</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Donald W. Minzner</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>9/5/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DONALD W. MINZNER</u>				22e. ADDRESS <u>3009 EVERGREEN RD BALTO</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Sept. 4, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran</u>		23d. LOCATION CITY OR TOWN <u>Parkville</u> COUNTY <u>Balto</u> STATE <u>Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Leonard J. Ruck Inc.</u> ADDRESS <u>Baltimore, Maryland</u>				25a. DATE REC'D. BY REGISTRAR <u>SEP 5 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Wardson-Randall</u>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 4 23761	
1. DECEASED NAME (TYPE OR PRINT) <b>VIRGINIA ELIZABETH Riordan</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>09/09/1984</b> 2b. HOUR <b>2:30 PM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09/06/1919</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>65</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) (STATE OR FOREIGN) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL, BALTO.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Catonsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Satterfield</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel M. Woodrow</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-10-1315</b>		17. INFORMANT ADDRESS <b>Severn, Md. 21144</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY</b> DUE TO, OR AS A CONSEQUENCE OF <b>ASPIRATION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARREST</b> DUE TO, OR AS A CONSEQUENCE OF <b>COMA</b> (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION <b>8/22/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>STRANGULATED UMBILICAL HERNIA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK NOT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/21</b> , 19 <b>84</b> , to <b>9/9</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>9/9</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Kushal</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/9/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/></b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		23b. DATE <b>9-13-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Maus.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 11 1984</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>1050 York Rd. Towson, Md. 21204</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

VIRGINIA WILLIAMSBURG RICHMOND

male white

Maryland U.S.A. x

Retired State of Md.

Maryland Baltimore Catonsville x 1100 Stanford Rd. 21229

Howard Eatherfield Ethel M. Woodrow  
218-10-1312 Howard E. Eatherfield, 895 Richmond Rd.  
Crown, Md. 21144

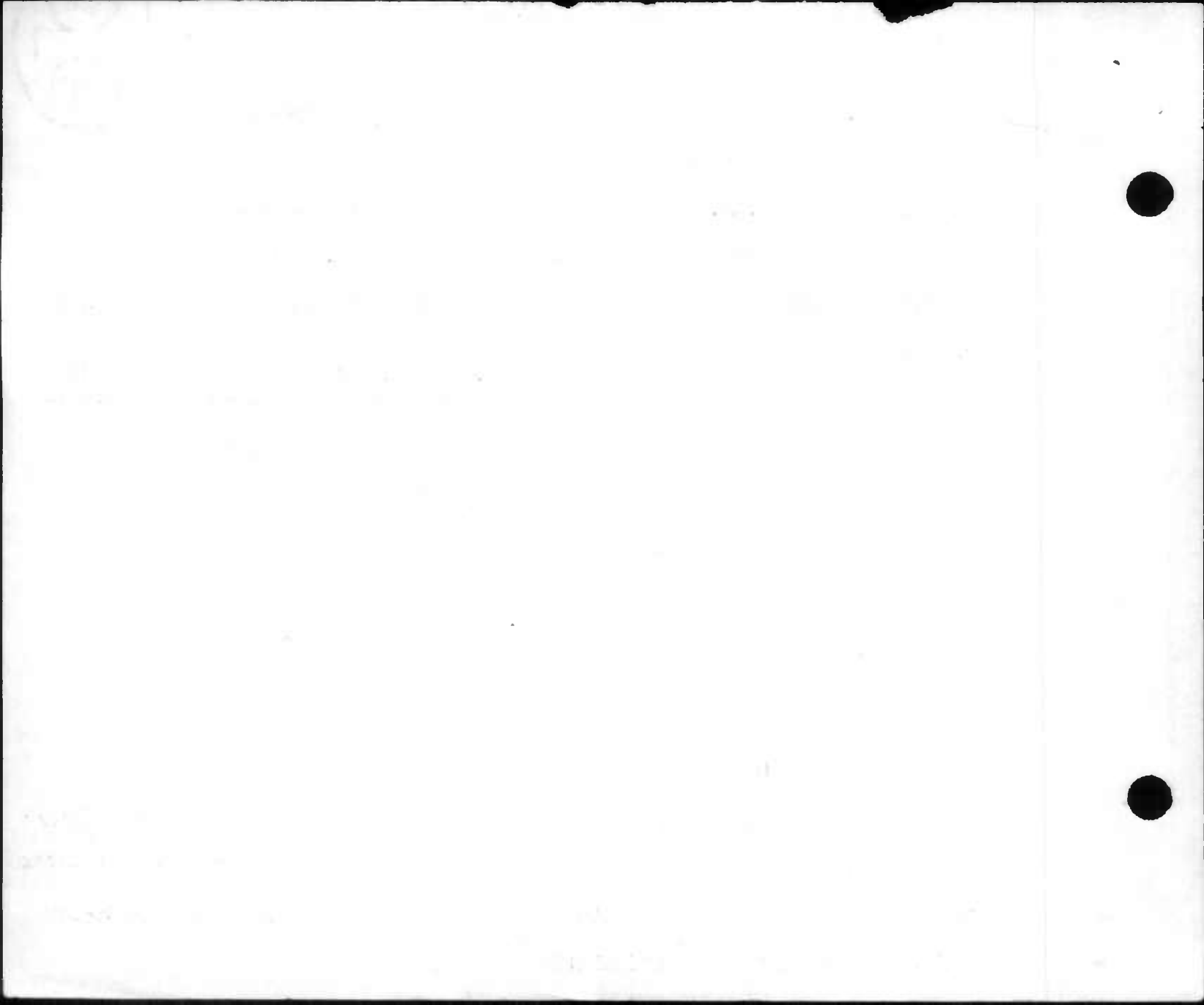
Interment 2-13-64 Eastern Park Maus. Baltimore  
1020 York Rd.  
Inch Towson Funeral Home, Inc. Towson, Md. 21204



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mr. James Thomas Ritter Sr.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>September 4 1984</b>		2b. HOUR M <b>A</b>	
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 27 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Pikesville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pikesville Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Balt. County</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Battalion Chief</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>7433 Inwood Avenue 21228</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>E. Frank Ritter</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Townsend Ritter</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>217-01-9479</b>		17. INFIRMARY ADDRESS <b>7433 Inwood Avenue Baltimore</b>		21228 Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Alzheimer's disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Decubitus ulcer</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11. 9. 19. 83</b> to <b>Aug 24th 19. 84</b> that (I) (we) last saw the deceased alive on <b>Aug 24th 19. 84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>F. Kawaja</b>		DEGREE		22c. DATE SIGNED <b>9/5/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Tahoora Kawaja</b>		22e. ADDRESS <b>8204 Liberty Rd, Baltimore</b>		22f. CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>09-07-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown Baltimore Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133</b>		25a. DATE REC'D BY REGISTRAR <b>SEP 6 1984</b>		25b. REGISTRAR'S SIGNATURE <b>W. Harrison Randall</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for a post-mortem examination.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) <b>CHARLES Edward Roberts</b>		3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>May</b> DAY <b>2</b> YEAR <b>1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VALLEY NURSING + CONV. Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Agricultural</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Sparks</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1415 Glencoe Road, #21151</b>		14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Fox</b> LAST <b>Roberts</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ada</b> MIDDLE <b>E.</b> LAST <b>Francis</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>530-18-2614</b>		17. INFORMANT <b>Mrs. Nellie May Roberts</b>		ADDRESS <b>Sparks, Md. 21152</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Cancer of Prostate</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE <b>GARY A MANKO</b>												DEGREE <b>MD</b>				22c. DATE SIGNED <b>9-14-1984</b>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY A. MANKO</b>												22e. ADDRESS <b>11722 REISTERSTOWN RD, Reisterstown, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>17 Sept 1984</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove UMeth Cem</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Phoenix, Balto. Co., Md.</b>															
24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b> ADDRESS <b>10 W. Padonia Road</b>												25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1984</b>				25b. REGISTRAR'S SIGNATURE <b>J. A. Davidson-Randell</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Herman J. Roberts			2a. DATE OF DEATH MONTH DAY YEAR 9 17 84			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 24 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7533 Holabird Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer-Martin		12b. KIND OF BUSINESS OR INDUSTRY Marietta	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Patrick E. Roberts			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elva Mae Ketterman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT 6208 W. Mariposa Dr. Phoenix, Arizona 85033		17. INFORMANT Marcus Roberts	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary arteriosclerosis + Atrial</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Valve + aortic Valve Area</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (if) (was) lost saw the deceased alive on <u>8-13-84</u> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>George Heberka</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-18-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE HEBERKA MD				22e. ADDRESS 7839 WISE AVE. Balt MD			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9/21/84		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Phoenix Arizona	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE REC'D. BY REGISTRAR SEP-21 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

4 2 3 7 6 5

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH Mae ROBERTS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 10 84</b>			2b. HOUR <b>6<sup>PM</sup></b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 11 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		
13a. STATE <b>Illinois</b>			13b. COUNTY <b>Williamson</b>		13c. CITY OR TOWN <b>Marion</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1202 West Stockton</b> 62959	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jasper</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Willie Latham</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT <b>Severn, MD</b> ADDRESS <b>21144</b> <b>Mrs. Collette Norman</b> 7884 Huguenot Ct.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/7/84</b> to <b>9/10/84</b> , that (I) (we) last saw the deceased alive on <b>9/10/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Loring Byers MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/10/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. DEPESTRE</b>						22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSP</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/14/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marion Williamson Illinois</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 11 1984</b>				
8728 Liberty Rd. Randallstown, MD 21133						25b. REGISTRAR'S SIGNATURE <b>Gelia Davidson-Randall</b>				

MEDICAL CERTIFICATION

